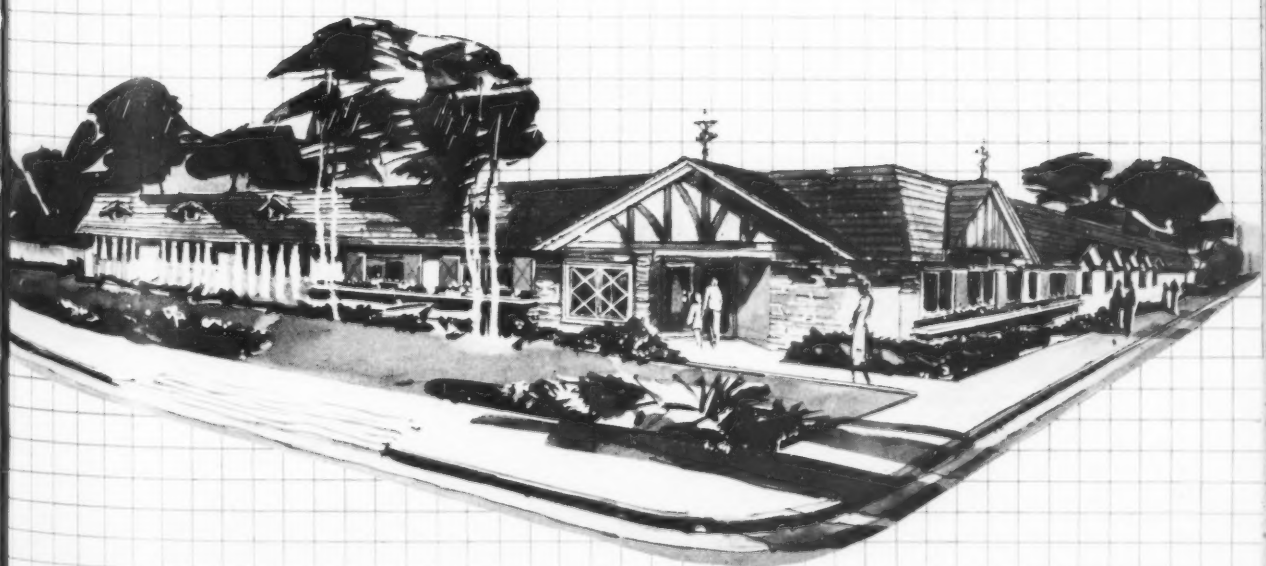
Hospital Topics

TODAY'S HOSPITAL PRACTICES

SEPTEMBER 1960

PLANNING THE DIETARY FACILITY: CONVALESCENT HOSPITAL



IN TOTAL HOSPITAL WAR AGAINST STAPH.

antibacterial detergent with 3% hexachlorophene

pHisoHex®

for all personnel with patient contacts

Thorough washing with the antiseptic detergent, pHisoHex, is a simple hygienic measure that can help reduce staphylococcal and other infections if adopted by **all hospital personnel attending patients.** Such a hospital procedure has "...proved effective in controlling the spread of infection...."[1] Routine washing with pHisoHex is suggested not only for surgeons, physicians and nurses, but also for nurses' aids, food handlers and members of the housekeeping and laundry staff. Home use by surgeons and nurses augments results still further.

"...the bactericidal effect of pHisoHex can be attributed to the efficient deposition of hexachlorophene as a semi-permanent film on the skin of frequent users."[2] Hexachlorophene is particularly effective against staphylococci.[3]

pHisoHex is a potent antibacterial, hypoallergenic detergent with "...a surface tension reducent 40% more powerful than soap."[2]

1. Benson, Margaret E.: **Am. J. Nursing** 57:1136, Sept., 1957. 2. Smylie, H. G.; Webster, C. U., and Bruce, M. L.: **Brit. M. J.** 2:606, Oct. 3, 1959. 3. Ayliffe, G. A. J.; Alder, V. G., and Gillespie, W. A.: **Lancet** 2:456, Sept. 26, 1959.

Winthrop LABORATORIES, New York 18, N. Y.

FIRST WITH . . .

COMPLETE POWER POSITIONING

PLUS "POWER-OFF" EMERGENCY CONTROLS

Power pack recessed in base. No extra housing.

SHAMPAINE S-1500 O. R. TABLE SURG-A-POWER

FULL POWER POSITIONING

Set Position Selector. Simple push or pull movement activates power and obtains any desired position—automatically.

FULL TIME MECHANICAL CONTROLS

You're never stranded! In case of electrical power interruption or related failure . . . mechanical controls are always ready to take over and shift table to any position. Set selector and activate foot pedal!

UNOBSTRUCTED HEAD-END

Single control arm provides unobstructed area for close patient contact from head-end . . . with table in chair position.

TWO-WAY ELEVATION

1 – Power on: press foot button at left.

2 – Power off: activate foot pedal at right.

To lower table with power on or off . . . depress foot pedal at right.

Shampaine COMPANY

1920 SOUTH JEFFERSON • ST. LOUIS, MO.

Entire table U. L. Listed for Class I, Group C atmosphere

a SHAMPAINE Industry

For further information see postcard opposite page 116.

IN TOTAL HOSPITAL WAR AGAINST STAPH.

antibacterial detergent with 3% hexachlorophene

pHisoHex®

for all personnel with patient contacts

Thorough washing with the antiseptic detergent, pHisoHex, is a simple hygienic measure that can help reduce staphylococcal and other infections if adopted by **all hospital personnel attending patients.** Such a hospital procedure has "...proved effective in controlling the spread of infection...."[1] Routine washing with pHisoHex is suggested not only for surgeons, physicians and nurses, but also for nurses' aids, food handlers and members of the housekeeping and laundry staff. Home use by surgeons and nurses augments results still further.

"...the bactericidal effect of pHisoHex can be attributed to the efficient deposition of hexachlorophene as a semi-permanent film on the skin of frequent users."[2] Hexachlorophene is particularly effective against staphylococci.[3]

pHisoHex is a potent antibacterial, hypoallergenic detergent with "...a surface tension reducent 40% more powerful than soap."[2]

1. Benson, Margaret E.: **Am. J. Nursing** 57:1136, Sept., 1957. 2. Smylie, H. G.; Webster, C. U., and Bruce, M. L.: **Brit. M. J.** 2:60[illegible] Oct. 3, 1959. 3. Ayliffe, G. A. J.; Alder, V. G., and Gillespie, W. A.: **Lancet** 2:456, Sept. 26, 1959.

Winthrop LABORATORIES, New York 18, N. Y.

FIRST WITH . . .

COMPLETE POWER POSITIONING

PLUS "POWER-OFF" EMERGENCY CONTROLS

SHAMPAINE S-1500 O. R. TABLE SURG-A-POWER

FULL POWER POSITIONING

Set Position Selector. Simple push or pull movement activates power and obtains any desired position—automatically.

FULL TIME MECHANICAL CONTROLS

You're never stranded! In case of electrical power interruption or related failure . . . mechanical controls are always ready to take over and shift table to any position. Set selector and activate foot pedal!

UNOBSTRUCTED HEAD-END

Single control arm provides unobstructed area for close patient contact from head-end . . . with table in chair position.

TWO-WAY ELEVATION

1 - Power on: press foot button at left.
2 - Power off: activate foot pedal at right.

To lower table with power on or off . . . depress foot pedal at right.

Shampaine COMPANY

1920 SOUTH JEFFERSON • ST. LOUIS, MO.

a SHAMPAINE Industry

Entire table U. L. Listed for Class I, Group C atmosphere

For further information see postcard opposite page 116.

First from American

New ideas, new products for pediatrics...

through one service expert!

American representatives understand pediatrics needs. They offer valuable experience and expert counsel in every hospital area... and the widest, most complete selection of products and services in the field. You can rely on *American's* reputation for quality and for prompt, dependable delivery. Your man from *American* is dedicated to your hospital's best interests... call him with confidence.

Meet Art Towner. Like many *American* men, Art Towner is regarded as a professional consultant first, a salesman second. During 38 years as an American representative, Art has traveled more than 1,800,000 miles to make some 50,000 calls in midwestern health institutions.

The First Name in Hospital Supplies

AMERICAN

2020 RIDGE AVE., EVANSTON, ILLINOIS Regional Offices: Atlanta • Boston • Chicago • Columbus • Dallas

Export Department: Flushing 58, L. I., N. Y., U. S. A. In Canada—Fisher & Burpe, Division of American Hospital Supply Corporation (Canada) Limited.

N

• Dallas

da) Limited,

Hospital Supply Corporation

Kansas City • Los Angeles • Miami • Minneapolis • New York • San Francisco • Washington

Winnipeg 12, Manitoba. In Mexico—Hoffmann-Pinther & Bosworth, S. A., Mexico 1, D. F., Mexico.

Adams Silicone Skin Spray prevents bed sores and skin irritations

Now, Clay-Adams has made available a product which provides the skin-soothing properties of silicone and the bacteriostatic action of hexachlorophene *in an aerosol spray.*

ADAMS SILICONE SKIN SPRAY...

Highly Effective. It forms a durable, bacteriostatic, moisture-resistant coating that protects sensitive skin from irritating body fluids and medicaments.

Reduces Cross Infection. Spray easily applied without touching patient...minimizes nurse-transfer of infection.

Won't Harm Dressings. Excellent protection for skin areas surrounding ileostomies, colostomies and biliary drainage cases.

Pleasantly Scented. An important advantage in many cases.

Economical. Two applications daily afford ample protection from irritation. One can lasts for approximately 60 days.

ORDER NOW FROM YOUR DEALER. Adams Silicone Skin Spray is available in convenient 12 oz. aerosol can at $4.50 (considerably less when ordered in quantity).

Clay-Adams
NEW YORK 10

HOSPITAL Topics

SEPTEMBER, 1960, VOL. 38, NO. 9

G. M. MARSHALL
Publisher

Editorial Staff
MARIE JETT
Editor

ELLEN L. DAVIS
Feature Editor

JOHN G. STEINLE
Consulting Editor

J. F. FLEMING, M.D.
Medical Editor

MONA NELSON
JOAN BOWDEN
Staff Writers

CAROL J. BLEACKLEY
Editorial Assistant

ROSEMARY SCHULTHEIS
Advertising Production

Business Staff
MARCELLA SKANDIS
JOHN KINNEY
Assistants to the Publisher

JOHN HINSE
JOHN HOGENSEN
JACK C. SMITH
Advertising Representatives

FEATURES

20 Decatur and Macon County Hospital's Intensive All-Employee Training Program
Ellen L. Davis

26 Two Hospitals Raise $4 Million in Community Effort
Sister M. Mirella and Franklin E. Simek

29 Efficient Operation Keeps PT Out of the Red
Mona Nelson

37 Planning the Dietary Facility for a Convalescent Hospital
Christine R. Pensinger

40 Institutional Sanitation: Principles and Technics
Howard Gadberry

45 Our Beauty Bar is a Money Maker
Ruth V. Requa

DEPARTMENTS

9 Scanning the News

11 News Briefs at Press Time

19 Consultant's Corner
John G. Steinle

(Continued on page 7)

Published monthly by HOSPITAL TOPICS, INC. Publication office: 30 West Washington St., Chicago 2, Ill. Telephone DEarborn 2-5148.

Eastern Sales Office: 15 W. 44th St., New York 36, N. Y. Telephone OXford 7-5262.

Subscription rates: one year, $4.50; two years, $7.00; three years, $9.00; single copy, 65 cents. Canadian and foreign subscriptions: one year, $5.50; two years, $9.00; three years, $12.00; single copy, 75 cents. Entered as second class matter at the Post Office, Chicago, Ill. Additional entry at Barrington, Ill.

Change of address notices, undeliverable copies, and subscription orders should be sent to: HOSPITAL TOPICS, 30 West Washington St., Chicago 2, Ill.

Copyright 1960 by Hospital Topics, Inc.,
All rights reserved.

Dignity
AND CONFIDENCE IN LABELING
STERILE FOLEY CATHETER FR. SIZE
STERILE SIZE HYPODERMIC SYRINGE 10CC.
SIZE
GLOVES 7½
BEFORE AUTOCLAVING
TSI (TIME STERILE INDICATOR)
ARTICULATES THE ACT
OF STERILIZING
IT IS A SCIENTIFIC CHEMICAL REAGENT APPLIED TO A SELF-STICKING TAPE. THE WORD "STERILE" APPEARS IN BLACK ON THE TIME AUTOCLAVE LABEL ONLY AFTER IT HAS BEEN SUBJECTED TO AUTOCLAVE TEMPERATURES OF 250° F. FOR AT LEAST 15 MINUTES. NOT A NOVELTY . . . GIVES PROPER LABELING OF ARTICLE.
STERILE NORMAL SALINE
STERILE 4x4 SPONGES
STERILE SIZE GLOVES 7½
AFTER AUTOCLAVING
SEALS AND IDENTIFIES
SHOWS SIZE AND NUMBER
GIVES PROOF OF STERILIZATION
ELIMINATES PENCIL MARK MISTAKES
500 NOMENCLATURES AVAILABLE
PROFESSIONAL TAPE COMPANY, INC. • 355 BURLINGTON AVENUE • RIVERSIDE, ILLINOIS
TIME LABELS

TABLE OF CONTENTS

(*Continued from page 5*)

49 **Health Insurance Newsletter**
George R. Metcalf

51 **Review of Hospital Lawsuits**
Leo T. Parker

55 **Pharmacy**
Well-Planned Layout Improves Efficiency
Pat Murphy, R.Ph.
Prescription Pad

63 **Lab**
Checks and Rechecks Halt Transfusion Errors
E. S. Olson, M.D.

67 **Pediatrics and OB**
Feeding Solids to Newborns

87 **Central Supply**
Making Better Utilization of People and Materials
Marie Dzupin, R.N.

95 **Personally Speaking**

101 **Book Corner**

102 **Buyer's Guide**

110 **Films and New Literature**

113 **Trade Topics**

OPERATING ROOM

75 **Orienting Medical Students at Peter Bent Brigham**
Rose Tashjian, R.N.

77 **Mental Health in the Operating Room**
Grace T. Gould, R.N.

82 **O.R. Question Box**
Carl W. Walter, M.D.

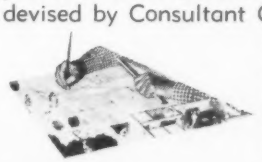
83 **Selected Bibliography**
Dorothy W. Errera, R.N.

84 **Plans Progressing for 1961 AORN Congress**

85 **Floor Plan of Congress Exhibit Area**

THIS MONTH IN HOSPITAL Topics—

- Decatur and Macon County Hospital, Decatur, Ill., is the source of TOPICS' on-the-spot report of hospital-wide training programs designed for "best patient care, best workers, and best public relations." Basis of D&MC philosophy is that management belongs in the hands of management specialists, freeing professional workers to concentrate on their special areas of operation. Training programs, integrating administration, education, and public relations, are intensive, include all personnel (page 20).
- Why do the physical therapy departments in some hospitals pay for themselves, while others are a financial hazard? Part of the answer lies in efficient operation and the ability to "make do" with available facilities and personnel. TOPICS spotlights two well-run PT departments in the story on page 29.
- When two community hospitals who have in the past had difficulty in raising limited funds, then embark on a $3 million campaign which goes way over its goal, that's news. For the story behind it, see page 26.
- Sometimes more than pills and prescriptions are needed to bring a rosy glow to a patient's cheek. Nassau Hospital's Rx is a hospital beauty bar. Run by the women's auxiliary, the beauty bar builds the morale of women patients, helps to attract hard-to-get nurses, and actually produces revenue (page 45).
- The increase in hospital infections in the last few years demands a better understanding of the basic principles and applications of effective sanitation. Howard Gadberry of the industrial chemistry section, Midwest Research Institute, gives TOPICS readers a thorough view of the subject in "Institutional Sanitation," page 40.
- On TOPICS' cover: architect starts working drawings for dietary facility, Bonnie Brae Convalescent Hospital, after approval of three-dimensional scale model, devised by Consultant Christine R. Pensinger. Below is architect's drawing of building. Story appears on p. 37.

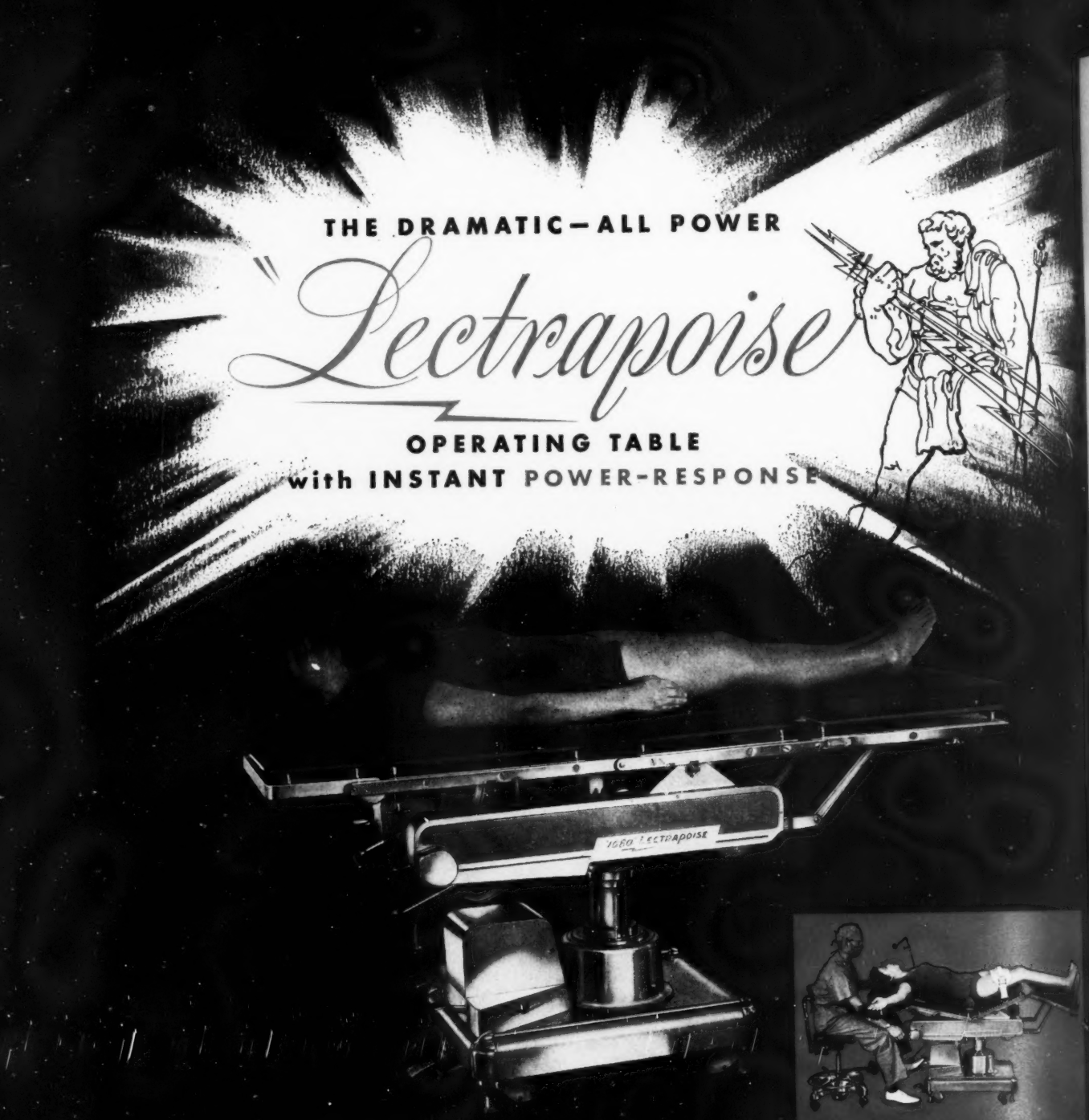


THE DRAMATIC—ALL POWER

Lectrapoise

OPERATING TABLE

with INSTANT POWER-RESPONSE



Simple Head End power controls enable the anesthesiologist to articulate the "Lectrapoise" instantly — smoothly. No other table offers this surgical convenience and maneuverability.

In every sense Amsco's remarkable new "Lectrapoise" Operating Table answers the surgeon's need for smooth power-positioning . . . ultimate in surgical convenience.

A number of new engineering features set the "Lectrapoise" above all other operating tables . . . "power-response" positioning . . . quick-grip mattress pad . . . full length X-ray top . . . new clamp-on legholder sockets . . . emergency positioning . . . and complete standard accessories.

Every surgeon, anesthesiologist and every hospital will appreciate the significantly finer qualities of the "Lectrapoise." For once they power this compact table through its surgical postures, there can be no substitute.

Write for fully illustrated 26-page brochure TC-299.

AMSCO

AMERICAN STERILIZER

ERIE • PENNSYLVANIA

World's largest designer and manufacturer of Operating Tables, Lights, Sterilizers and related equipment for hospitals

HOSPITAL Topics
The News Magazine for the Hospital Staff

SEPTEMBER, 1960
VOL. 38, NO. 9

Scanning the News

High Speed Film Catches Stomach in Action

The human stomach is revealing its innermost secrets via high-speed color film in a technic developed by Henry Colcher, M.D. and George M. Katz of the Columbia University Research Service, Goldwater Memorial Hospital and the Columbia - Presbyterian Medical Center.

An 8mm motion picture camera is mounted on the eyepiece of a gastroscope to which light-transmitting glass fibers are attached. Sensitive color film insures satisfactory movie production under the comparatively low level of illumination.

Although research concerning methods of picturing "blind" areas of the stomach is still in progress, Drs. Colcher and Katz report that satisfactory color motion pictures have already been obtained at 8 frames per second with the new technic.

Junior's Piano Sessions Can't Hurt Dad's Ears

Constant exposure to piano sound, such as a professional pianist would experience, does not lead to hearing loss, state Godfrey E. Arnold, M.D., and Francis Miskolczy-Fodor, M.D., both of the New York Eye and Ear Infirmary.

The two doctors elicited the cooperation of New York's Juilliard School of Music and the Piano Teachers Congress of New York in a study covering 30 professional pianists and piano teachers.

Because it was felt that older persons might show a possible occupational hearing loss more clearly than younger pianists, the study covered 10 men and 10 women aged 60 to 69, and 10 women aged 70 to 80.

And the music is "somethin' grand" as (l. to r.) Sister Mary Theresa, Opal Davis, and Doris Casey, of St. Vincent's Hospital, St. Louis, Mo., check instruments available to the hospital's rhythm band. The instruments are a part of the occupational therapy employed in treating psychiatric cases. According to Sister Mary Theresa, supervisor of the OT department, the rhythm band appeals especially to the more withdrawn patients, offering an opportunity to participate in an inconspicuous and impersonal way.

It was found that the hearing acuity of the test group was better than that found in the general population. There was no evidence of traumatic hearing loss.

Piano sound ranges in levels around 70 decibels and the peak levels of a climax do not exceed 95 decibels. Sound in these intensities does not produce acoustic trauma.

Lowly Aspirin New Miracle Drug?

Small doses of aspirin can lower blood cholesterol, relieve the symptoms of diabetes, and can act like thyroid where there is insufficient metabolic activity, according to Dr. Chauncey D. Leake, professor of pharmacology and assistant dean of the medical school, Ohio State University.

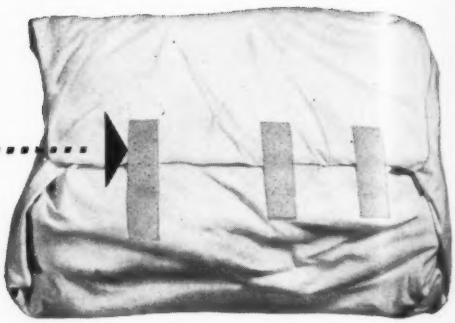
Salicylic acid preparations have long been used for relief of rheumatic pain. Now aspirin has been found to stimulate the hormone system of the body, creating an increased flow of the hormones necessary for healthy activity.

Dr. Leake states that aspirin's therapeutic action in diabetes mellitus is "startling." It reduces blood sugar and glycosuria, controls ketosis, improves glucose tolerance, and supplements the action of insulin.

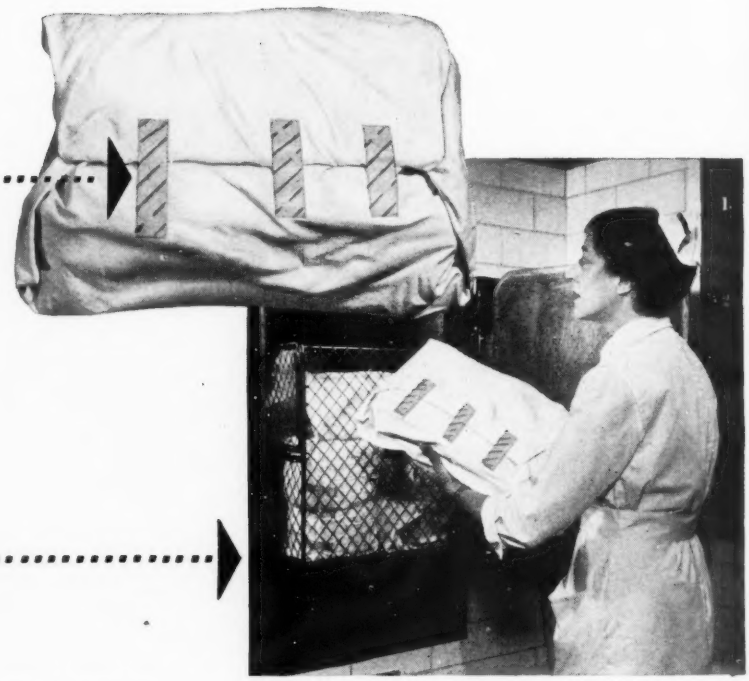
Under its common name, aspirin

(*Continued on page* 46)

The only thing that can change this.....



...to this.....



...is this!.....

The special indicator inks used in "SCOTCH" BRAND Hospital AutoclaveTape cannot be accidentally activated by sunlight, radiator heat or a dry air pocket in a faulty autoclave. Only correct levels of heat and moisture found in your autoclave can make these unmistakable diagonal markings appear!

The distinctive markings on "SCOTCH" BRAND Autoclave Tape can be seen across the room. You can tell at a glance that your pack has been through the autoclave. "SCOTCH" BRAND sticks at a touch to paper or linen packs. Seals securely, surely. Peels off clean without leaving sticky residue. And you can write on it.

Nothing on the outside of a bundle, of course, can guarantee sterility of the contents.

Insist on dependable SCOTCH® BRAND HOSPITAL AUTOCLAVE TAPE NO. 222

"SCOTCH" is a registered trademark of 3M Co.

MINNESOTA MINING AND MANUFACTURING COMPANY

...WHERE RESEARCH IS THE KEY TO TOMORROW

3M COMPANY

For further information see postcard opposite page 116.

News Briefs at Press Time

HEALTH CARE FOR THE AGED: CONFUSION REIGNS IN CONGRESS

As TOPICS goes to press in mid-August, the one sure statement that can be made about legislation for medical care of the aged is that the whole situation is very, very confused—and what will happen is anybody's guess.

Many congressmen have tried to avoid being pinned down too specifically on this important campaign issue. Washington correspondent Gerald Gross, who publishes a weekly newsletter, reports that he asked some three dozen senators and representatives to answer a brief questionnaire on national health legislation. He got few responses, and far more expressions of regret.

In the first week of the reconvened session, Democratic senators, including nominees Kennedy and Johnson, again declared they would push for passage of legislation for health care of the aged.

At week's end Senate Finance Committee approved plan calling for joint federal-state participation and financing. Kennedy indicated he would fight for plan under Social Security system.

A vast supply of material which may or may not help the senators make up their minds is contained in the recently published 531-page volume of testimony taken by Senate finance committee at public hearings June 29 and 30. Book includes all 27 of the proposed amendments to the House-passed social security bill (HR 12580) which were introduced by senators before and during the hearings. Among these are Anderson and McNamara amendments, which were expected to receive the committee's close attention.

DOCTOR FORESEES MORE MEDICAL STAFF INTEGRATION IN CHICAGO HOSPITALS

The Chicago physician who was chairman of a committee on hospital, patient and staff integration predicted recently that voluntary hospitals in that city may be forced to admit more Negro physicians as staff members and more Negro patients—forced by a serious shortage of patients needed for instruction of interns.

Only 20 of Chicago's 210 Negro physicians have appointments in private hospitals primarily for whites—an increase of only four since 1956, according to Dr. Quentin D. Young, who headed the joint committee appointed by the Institute of Medicine of Chicago and the Chicago Medical Society. Only 12 of Chicago's 65 accredited, predominantly white hospitals have Negro staff physicians.

Dr. Young said he was very optimistic that the Chicago Medical Society would formulate some action to take in the early fall. He praised three hospitals—Children's Memorial, Alexian Brothers, and Michael Reese—for their successful pioneering efforts in patient and staff integration.

MINNESOTA MEDICAL OPPOSES BLUE CROSS OUTPATIENT DIAGNOSTIC COVERAGE

Minnesota State Medical Association at its annual meeting approved a strong resolution asking the state's Blue Cross not to offer outpatient diagnostic coverage to its subscribers. Physicians sponsoring the resolution contended that such coverage would transfer the doctor's functions to the hospital.

Issue was one factor that contributed to split between Blue Cross and Blue Shield in Minnesota about six months ago. Blue Shield is now setting up its own administration and sales force.

BRIEF BRIEFS

—If Republicans try to make good on their platform pledge to oppose use of U. S. funds for construction of segregated community facilities, Sen. Lister Hill (D., Ala.) is expected to fight any attempt to drop the separate-but-equal clause in Hill-Burton Act.

—Pharmaceutical industry spent $197 million on research in 1959, according to final figures in third annual survey. More than $18 million was in form of grants to medical schools, hospitals, and other institutions.

—James P. Dixon, M.D., president of Antioch College and former Philadelphia health commissioner, has been appointed to National Advisory Health Council.

—AMA has announced formation of a new department of nursing to carry on liaison with national nursing organizations. Its director is Mrs. Veronica L. Conley, for the last 12 years secretary of AMA's committee on cosmetics. She holds an M.A. degree in nursing and a Ph.D. degree in education.

—General practitioners make up 30 percent of the staffs of 135 hospitals surveyed by the California Academy of General Practice. Sixty percent of these hospitals have a department of general practice, according to survey.

—Central artery bank maintained by the Chicago Heart Association since 1955 has been closed because of the development of economical plastic and fabric replacement vessels.

Gordon W. Marshall

Calendar of Meetings

SEPTEMBER

1- 2 National Association of Hospital Purchasing Agents, Jack Tar Hotel, San Francisco, Calif.

1- 7 International Congress on Nutrition, Sheraton Park and Shoreham Hotels, Washington, D. C.

4- 9 International Society of Orthopaedic Surgery and Traumatology, New York City

4-10 World Congress of Anesthesiologists, Toronto, Ont., Canada

11-15 International College of Surgeons, 12th Congress, New York City

12-16 AHA Institute, Nursing Service Administration, Lafayette Hotel, Buffalo

13-15 National Cancer Conference, American Cancer Society, and The National Cancer Institute, Minneapolis, Minn.

15-22 World Medical Association, Berlin-Hilton Hotel, West Berlin, Germany

18-20 Colorado Hospital Association, Stanley Hotel, Estes Park

18-21 International Meeting of Forensic Pathology, New York City

18-25 European Congress of Cardiology, Rome, Italy

22-23 Montana Hospital Association, Missoula

22-24 West Virginia Hospital Association, White Sulphur Springs

23-24 Regional Institute on OR Nursing, Association of Operating Room Nurses National Committee on Education, Coronado Hotel, St. Louis

24-27 College of American Pathologists, Palmer House, Chicago

25-29 National Recreation Congress, Shoreham Hotel, Washington, D. C.

26 Society for Pediatric Radiology, Ambassador Hotel, Atlantic City, N. J.

26-30 AHA Institute, Central Service Administration, AHA Headquarters, Chicago

27-30 American Society of Clinical Pathologists, Palmer House, Chicago

28-29 International College of Surgeons, U.S. and Canada Sections, Winnipeg, Man., Canada

28-Oct. 5 Pan-Pacific Surgical Association, 8th Congress, Honolulu, Hawaii

OCTOBER

2- 7 American Society of Anesthesiologists, Statler-Hilton Hotel, New York City

2- 7 American Society of Plastic and Reconstructive Surgery, Statler Hilton Hotel, Los Angeles

4 Hospital Association of Rhode Island, Sheraton-Biltmore Hotel, Providence

5- 7 AHA Institute, Hospital Laundry Management and Operation, AHA Headquarters, Chicago

5- 7 American Association for the Surgery of Trauma, Coronado Hotel, Coronado, Calif.

5- 8 American Academy for Cerebral Palsy, Penn-Sheraton Hotel, Pittsburgh

6- 8 American Association of Medical Clinics, Roosevelt Hotel, New Orleans

8 American Rhinologic Society, Belmont Hotel, Chicago

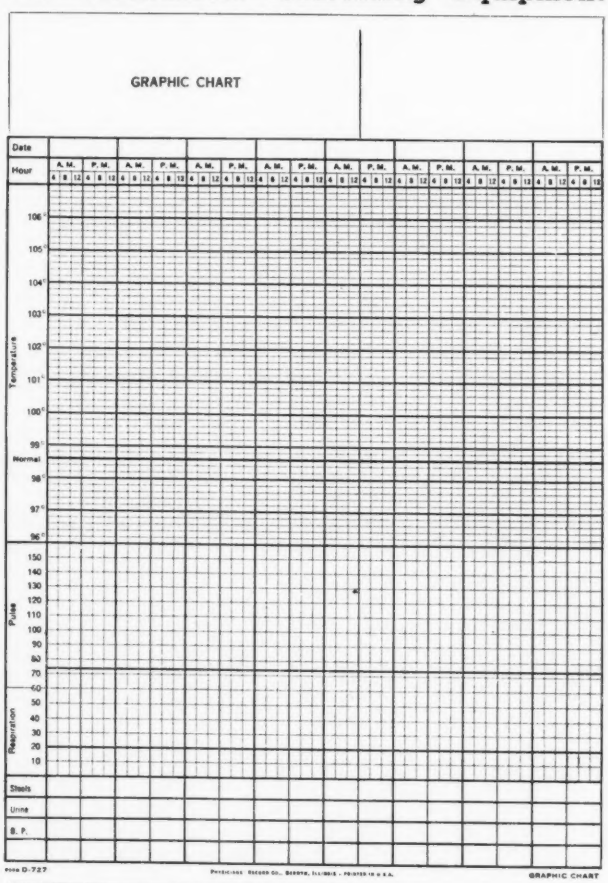
9 American Otorhinologic Society for Plastic Surgery, Conrad Hilton Hotel, Chicago

9 National Medical Foundation for Eye Care, Palmer House, Chicago

(Continued on page 14)

Standardized Hospital Record Forms

▼ For Mechanical Addressing Equipment



Low Cost • Timesaving • Authoritative

More Than 50 Forms . . . Available from Stock

▼ *Write to Dept. ADD for Sample Portfolio* ▼

Physicians' Record Company

Publishers of HOSPITAL and MEDICAL RECORDS Since 1907

3000 S. Ridgeland Avenue • Berwyn, Illinois

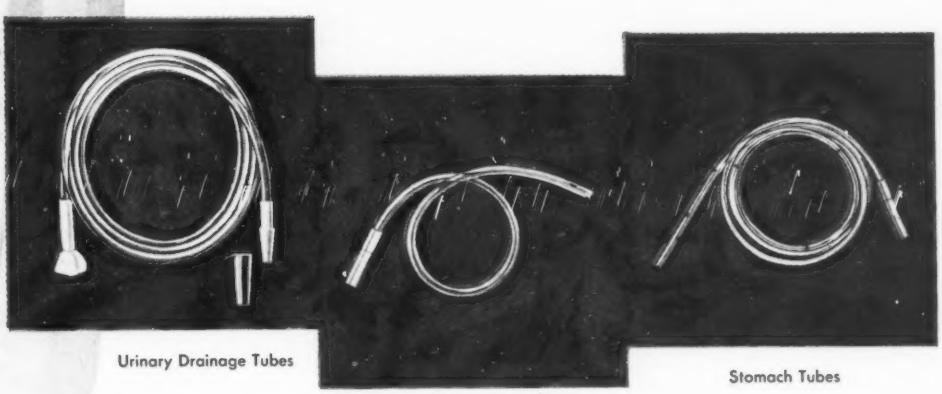
low price plus quality...

KENWOOD® PLASTIC TUBES

You can help your hospital control rising operating costs, save valuable time as well — with Kenwood Plastic Tubes. They're priced exceptionally low for one-time use, yet made of highest quality materials to take repeated reprocessing. Each tube is individually wrapped in heat-sealed polyethylene . . . sterile where required . . . ready for application without delay. Distal ends and eye openings have satin smooth edges — connectors and adaptors are permanently attached. Each tube is uniform, odorless, tasteless and non-toxic. *The quality is unconditionally guaranteed!* There's a Kenwood plastic tube for every use — ask your Will Ross, Inc. representative to show them all to you. Write for brochure.

WILL ROSS, INC.

General Offices: Milwaukee 12, Wis.
Atlanta, Ga. • Baltimore, Md.
Cohoes, N.Y. • Dallas, Texas
Minneapolis, Minn. • Ozark, Ala.



Urinary Drainage Tubes

Rectal Tubes

Stomach Tubes

PRODUCTS YOU CAN TRUST FROM PEOPLE YOU KNOW

For further information see postcard opposite page 116.

CALENDAR OF MEETINGS

(*Continued from page 12*)

9-14 American Academy of Ophthalmology and Otolaryngology, Palmer House, Chicago

10-12 Congress on Industrial Health, Hotel Charlotte, Charlotte, N. C.

10-13 AHA Institute, Evening and Night Nursing Service Administration, Pick-Roosevelt Hotel, Pittsburgh

10-13 American Association of Medical Record Librarians, Olympia Hotel, Seattle

10-14 National Federation of Licensed Practical Nurses, Cole Hotel, Albuquerque, N. Mex.

10-14 American College of Surgeons, Clinical Congress, San Francisco

12-13 Indiana Hospital Association, Indiana University Medical Center, Indianapolis

12-14 AHA Institute, Specialized Hospital Pharmacy, AHA Headquarters, Chicago

12-14 Maryland—District of Columbia—Delaware Hospital Association, Shoreham Hotel, Washington, D. C.

12-14 Saskatchewan Hospital Association, Bessborough Hotel, Saskatoon, Sask.

13 American Society of Facial Plastic Surgery, Chicago

13-14 Vermont Hospital Association, Burlington

13-15 Academy of Psychosomatic Medicine, Benjamin Franklin Hotel, Philadelphia

17-18 Idaho Hospital Association, Elks Lodge, Boise

17-18 Oregon Hospital Association, Gearhart Hotel, Gearhart

17-19 AHA Institute on Supervision, AHA Headquarters, Chicago

17-20 American Dental Association, Statler-Hilton Hotel, Los Angeles

17-20 AHA Institute, Management Development, AHA Headquarters, Chicago

17-20 American Academy of Pediatrics, Palmer House, Chicago

17-22 American Surgical Trade Association, Morrison Hotel, Chicago

18 American Association of Poison Control Centers, Palmer House, Chicago

18-21 American Dietetic Association, Sheraton Hotel, Cleveland

18-21 American Nursing Home Association, Mayflower Hotel, Washington, D. C.

19-20 North Dakota Hospital Association, Williston

19-20 Washington State Hospital Association, Davenport Hotel, Spokane

20-21 Nebraska Hospital Association, Sheraton-Fontenelle Hotel, Omaha

21-23 American Heart Association, Kiel Auditorium, St. Louis

24-26 AHA Institute, Directors of Hospital Volunteers, Basic, Statler Hotel, Boston

24-26 Ontario Hospital Association, Royal York Hotel, Toronto

24-28 California Hospital Association, Miramar and Biltmore Hotels, Santa Barbara

24-28 AHA Institute, Medical Social Work in Hospitals, Bellerive Hotel, Kansas City

25-26 South Dakota Hospital Association, Masonic Temple, Mitchell

25-27 Associated Hospitals of Manitoba, Royal Alexandra Hotel, Winnipeg, Man., Canada

25-27 Associated Hospitals of Alberta, Jubilee Auditorium, Edmonton, Alta., Canada

26-27 Industrial Hygiene Foundation of America, Mellon Institute, Pittsburgh

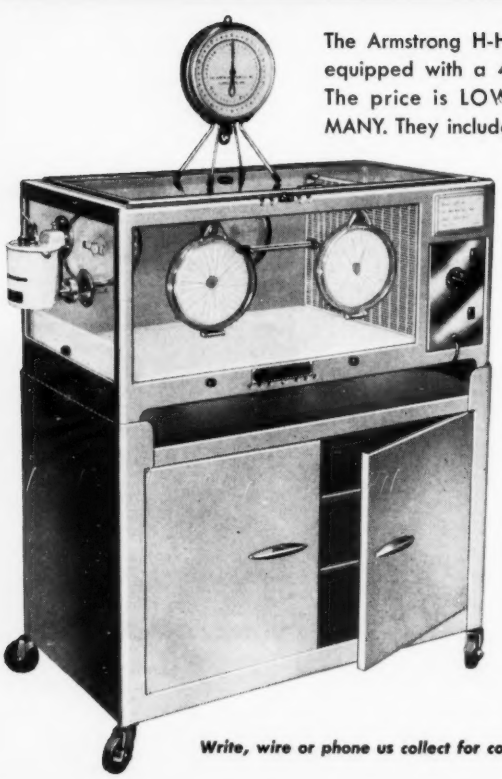
26-28 Association of State and Territorial Health Officers, Jack Tar Hotel, San Francisco

28-29 Regional Institute on OR Nursing, Association of Operating Room Nurses National Committee on Education, Cosmopolitan Hotel, Denver, Colo.

(*Continued on page 16*)

Armstrong H-H

Hand-hole type Baby Incubator



The Armstrong H-H is a LARGE incubator equipped with a 40% oxygen nebulizer. The price is LOW—the FEATURES are MANY. They include:

- 4-compartment mobile cabinet
- 40% oxygen limiting valve
- 3-stage humidity reservoir
- slide-opening for tube-feeding
- emergency opening top-lid—safety glass
- clear plexiglas ends and sides
- foam mattress with plastic cover
- 2 pre-shrunk weighing hammocks
- large enough for a 25-inch baby

Write, wire or phone us collect for complete details

The Gordon Armstrong Co., Inc.

514 BULKLEY BLDG.
CLEVELAND 15, OHIO
CHerry 1-8345

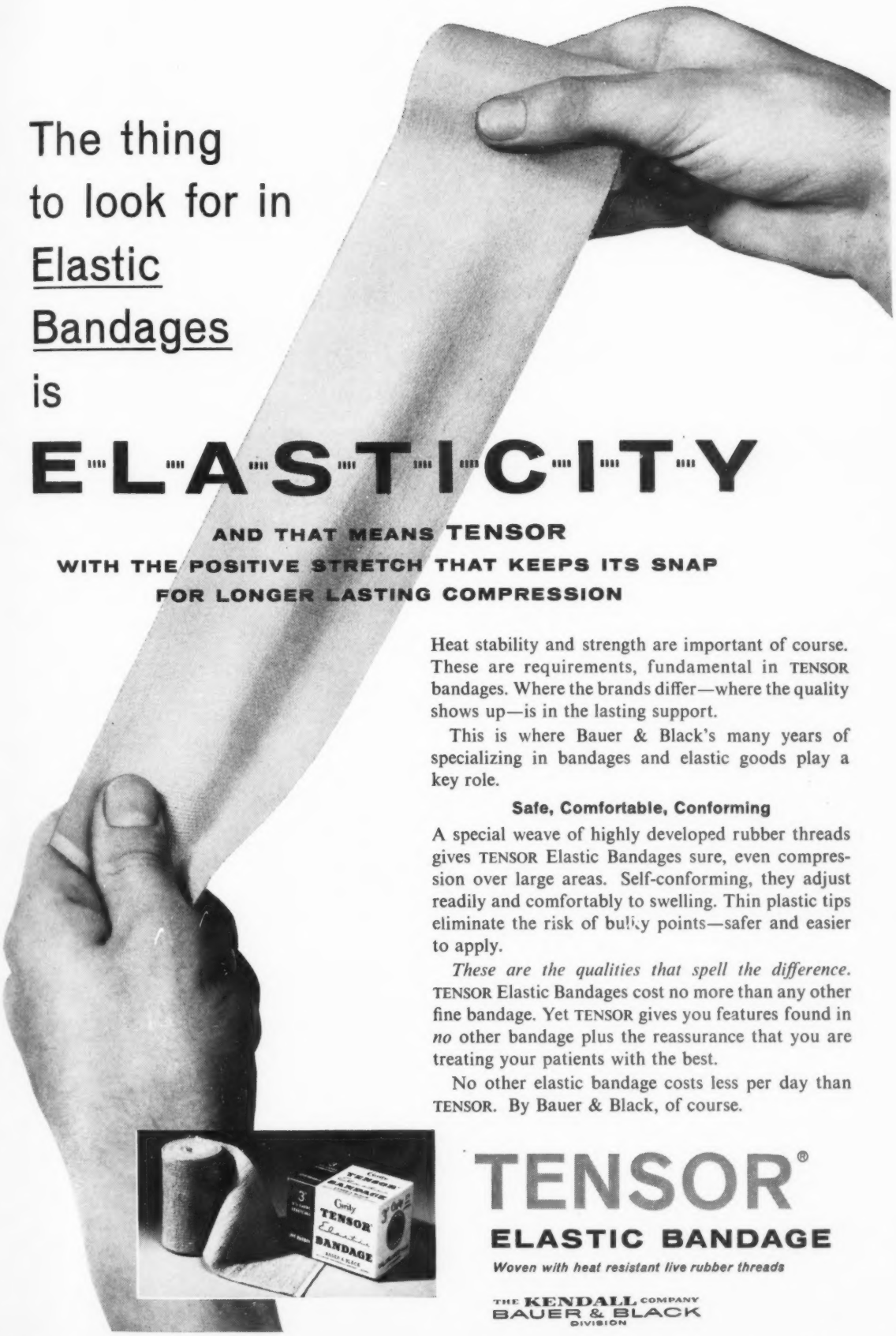
Armstrong Incubators are available in Canada from Ingram and Bell, Toronto, Ontario

The thing to look for in Elastic Bandages is

E·L·A·S·T·I·C·I·T·Y

AND THAT MEANS TENSOR

WITH THE POSITIVE STRETCH THAT KEEPS ITS SNAP FOR LONGER LASTING COMPRESSION



Heat stability and strength are important of course. These are requirements, fundamental in TENSOR bandages. Where the brands differ—where the quality shows up—is in the lasting support.

This is where Bauer & Black's many years of specializing in bandages and elastic goods play a key role.

Safe, Comfortable, Conforming

A special weave of highly developed rubber threads gives TENSOR Elastic Bandages sure, even compression over large areas. Self-conforming, they adjust readily and comfortably to swelling. Thin plastic tips eliminate the risk of bulky points—safer and easier to apply.

These are the qualities that spell the difference. TENSOR Elastic Bandages cost no more than any other fine bandage. Yet TENSOR gives you features found in *no* other bandage plus the reassurance that you are treating your patients with the best.

No other elastic bandage costs less per day than TENSOR. By Bauer & Black, of course.

TENSOR®

ELASTIC BANDAGE

Woven with heat resistant live rubber threads

THE KENDALL COMPANY
BAUER & BLACK
DIVISION

For further information see postcard opposite page 116.

CALENDAR OF MEETINGS

(*Continued from page 14*)

30 American College of Osteopathic Hospital Administrators, Statler Hilton Hotel, Dallas, Tex.

30-Nov. 4 American School Health Association, San Francisco

31-Nov. 2 Association of American Medical Colleges, Diplomat Hotel, Hollywood Beach, Fla.

31-Nov. 2 Association of Military Surgeons of the United States, Mayflower Hotel, Washington, D.C.

31-Nov. 3 American Osteopathic Hospital Association, Statler Hilton Hotel, Dallas, Tex.

31-Nov. 3 Interstate Postgraduate Medical Association of North America, Pittsburgh-Hilton Hotel, Pittsburgh

31-Nov. 3 AHA Institute, Staffing Departments of Nursing, AHA Headquarters, Chicago

31-Nov. 4 American Public Health Association, Civic Auditorium, San Francisco

NOVEMBER

2- 5 American Society of Tropical Medicine and Hygiene, Biltmore Hotel, Los Angeles

3- 4 Oklahoma Hospital Association, Skirvin Hotel, Oklahoma City

4- 5 Association of Clinical Scientists, Shoreham Hotel, Washington, D.C.

4- 5 Central Society for Clinical Research, Drake Hotel, Chicago

7-11 American Association of Medical Record Librarians, Basic Institute, co-sponsored with AHA, Fontainebleau Hotel, Miami Beach, Fla.

7-11 AHA Institute, Advanced Hospital Housekeeping, Sheraton-Atlantic Hotel, New York City

7-11 AHA Institute, Hospital Purchasing, AHA Headquarters, Chicago

7-11 AHA Institute, Physical Therapists, Ambassador Hotel, Los Angeles

10-11 Kansas Hospital Association, Broadview Hotel, Wichita

10-11 Virginia Hospital Association, Hotel Roanoke, Roanoke

11-12 Regional Institute on OR Nursing, Association of Operating Room Nurses National Committee on Education, Washington, D. C.

11-18 American Occupational Therapy Association, Statler Hilton Hotel, Los Angeles

14-17 AHA Institute, Nursing Service Supervision, Hotel Utah and Motor Lodge, Salt Lake City, Utah

14-18 American Association of Inhalation Therapists, Pick-Nicollet Hotel, Minneapolis, Minn.

16-18 Missouri Hospital Association, Hotel President, Kansas City

16-19 National Association for Mental Health, Denver-Hilton Hotel, Denver, Colo.

17-18 Minnesota Hospital Association, St. Paul Hotel, St. Paul

17-18 Arizona Hospital Association, Hiway House, Tucson

18-19 American Medical Writers' Association, Morrison Hotel, Chicago

21-22 AHA Institute, Credits and Collections, AHA Headquarters, Chicago

28-Dec. 1 American Medical Association, Clinical Meeting, Park-Sheraton Hotel, Washington, D.C.

29-Dec. 1 AHA Institute, Hospital Dental Service, Advanced, AHA Headquarters, Chicago

DECEMBER

1- 2 Florida Hospital Association, Everglades Hotel, Miami, Fla.

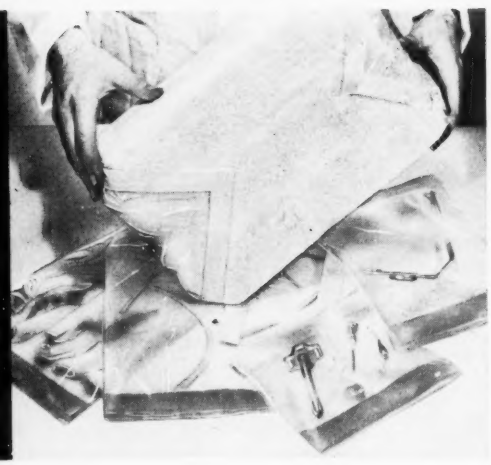
1- 2 Illinois Hospital Association, Pick-Congress Hotel, Chicago

2- 3 Regional Institute on OR Nursing, Association of Operating Room Nurses National Committee on Education, New Orleans, La.

DURABLE • REUSABLE TRANSPARENT

Sierra® NYLON AUTOCLAVABLE FILM

FOR *sealed package sterilization and sterile storage*



Highly effective, it is steam permeable yet impermeable to bacteria, keeping contents sterile till needed. Available in 12 widths from 1" to 20" and in 2 thicknesses. May be cut to desired length for single instruments or for packaging linens and dressings. Extremely durable and reusable for repeated autoclaving using normal sterilization technics up to 287° F. Transparent feature permits immediate identification of contents.

write for sample and descriptive literature

SIERRA ENGINEERING CO.

R. A. HAWKS DIVISION®

123 East Montecito • Sierra Madre, California

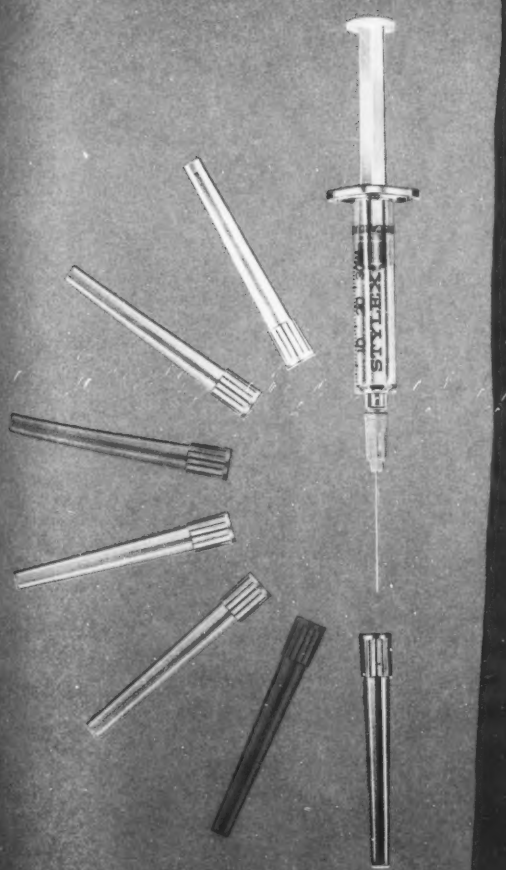
PHARMASEAL®

Stylex®

from every vantage point

the finest

disposable syringe



- **SAFETY**
- **ECONOMY**
- **CONVENIENCE**

Color Coding

to speed selection of desired needle sizes.

PHARMASEAL LABORATORIES
Glendale, California

The Finest
Plastic Tubes
are
PHARMASEAL®
Pharmaseal Laboratories • Glendale, California

Consultant's Corner

By John G. Steinle

In the July issue, I answered a question about proprietary hospitals, in which I stated that I believed there was a danger of conflict of interest on the part of the physician who had ownership in a hospital and who admitted patients to that hospital. . . . I received a good deal of mail, much of which was critical of my words and position. Following the usual policy of this column to give a fair opportunity to both sides of a question, here are some excerpts from letters received.

"Your answer to the first question on page 36 of *Hospital Topics* for July is disappointing and, I believe, too superficial to be of genuine help to the questioner.

"In the first place, you appear to have little faith in the American system of competitive enterprise. If all hospitals were operated frankly for profit, competition would very quickly bring into existence exactly the quality of hospital care for which the public would be willing to pay. Even with some hospitals operating for profit in competition with those ostensibly not so organized, the factor of competition could be more effective than it is now since the several hospitals in any community having more than one always seem to sell their services at about the same rates, regardless of the efficiency of operation.

"In the second place, you appear to have little faith in the integrity of physicians. No one has greater opportunity to take advantage of those who consult them than physicians. How does the patient really know whether or not he needs the operation? Here again you know very well indeed that the overwhelming majority of physicians practice with the strictest honesty and that only the occasional doctor takes advantage of his ever present opportunities to practice questionably.

"Your position on this question would indicate that you do not trust physicians to practice honestly in a hospital. If you do not trust them to practice honestly in hospitals, how can you trust them to practice honestly in the privacy of their offices? Logical extension of your argument would destroy the private practice of medicine. Are you prepared to say that there are better methods of serving the real needs of sick, injured, or distraught individuals?

"Finally your comparison with having an interest in a pharmacy has no logical relation to having an interest in a hospital. Few physicians have the knowledge or skills needed to operate or supervise the operation of a pharmacy. They do know a very great deal about how a hospital ought to be operated. Who but staff members set the standards? Who but staff members demand equipment permitting the best possible practice of medicine? Who but staff members write the orders? Who, after all, are really responsible for the quality of medical care rendered in hospitals?

"Actually, every hospital board should include one or more physicians. A lot of trouble would be avoided and a great deal of mutual understanding and respect would be engendered if this were universal practice."

* * *

"I refer you to the report entitled 'Highlights of Reports of the Average Length of Stay of Cases Paid by A.H.S. to Member Hospitals During the First and Second Six Months Period of 1959,' issued by A.H.S. in April 1960, which is very informative. I am sure you have a copy of the report in your files. The Blue Cross published figures state that the average stay of patients in voluntary hospitals is 9.14 days and the average stay of similar cases in proprietary hospitals is 7.04 days or 2.10 days less. Further that the payment per patient for all cases in member hospitals was $208.89; to United Hospital member hospitals $246.37 and to proprietary hospitals $182.50. The Blue Cross figures further show that of the total patient load about 26 percent was carried in private hospitals."

Q. What size hospital justifies electronic data processing over mechanical operations?

A. A very loose rule of thumb is 150 beds at present. This varies according to hospital, number of admissions, and activities included. Usually the activities included are: accumulation of accounts, accounts receivable, payroll, and inventory. The most complicated phase is probably the accumulation of items of charges, distribution of charges particularly to third party payors, and distribution of costs in the cost accounting system.

Decatur & Macon County Hospital's Intensive, All-Employee Training Programs

By

Ellen L. Davis

In the foreword of the 50-page employee training manual of the Decatur and Macon County Hospital, Decatur, Ill., Leon C. Pullen, Jr., administrator, states that the aim of the hospital's comprehensive training programs is to "help us provide the best care for patients, the best employees to accomplish this, and the best in public relations."

These are reasonable objectives, shared by administrators generally. But like most simply stated credos, the planning and functioning of the three-fold program has not been simple, especially since it has involved drastic change, to which most individuals react by instinct rather than by reason. If the road has occasionally worn a few bearings on the vehicle, it has also, however, been well-surveyed, well-posted, and notably clear of misconceptions and wishful thinking.

The factors that make for good patient care and good workers have been so thoroughly explored that even the pitfalls and handicaps are as familiar to most administrators as the backs of their own hands. "The best in public relations" is not so well charted, and many eager to profit from its fertility have been confused and disappointed by the terrain. The fact that oil is not struck does not indicate that oil is not there; rather, that the knowledge and technics applied have fallen short of penetration.

The interpretation of public relations is often nebulous and inaccurate, with a tendency to confuse publicity—a component of the subject—with the subject itself. That the interpretation among staff members at all levels at D&MC is realistic, and that public relations is regarded as an indispensable, everyday work tool must be recognized as a vital factor in the success of the over-all program.

"Public relations, as we see it," said Mr. Pullen, "is what you live with every day, which in the final analysis, is yourself and the other fellow, not the 'break' in the local paper or the success of a special event, though these are important results of putting the basic concept to work.

E. G. Merritt, training director, Dorothy Wallio, R.N. (standing), and Betty Cole, R.N., assistant director of nursing service, go over training programs planned for the nursing service department. Mrs. Wallio, together with Josephine Howard, R.N., make up the training department's "faculty." Both have degrees in education, and handle major portion of teaching assignments.

"As a worker, regardless of job status or type of work, what you do is bound to affect others. What I do as an administrator is going to affect in some way everyone connected with the hospital. I must

geared to best patient care

. . . best informed personnel

. . . best public relations

keep constantly in mind that there is no such thing as isolated action. This being so, every plan of action is revealed to all concerned before that plan goes into action. It is futile to keep *telling* people they are members of a team unless they are trained in plenty of hard practice sessions, and familiarized with all the signals and plays of the game."

Thus it was that the groundwork for the proposed training programs was laid before E. G. Merritt joined the staff as training director in 1957. Personnel knew that he possessed a degree in education, a background in public relations, and three years in the air force as a hospital administrative officer. They knew that administration considered it imperative that the training courses being given registered nurses, licensed practical nurses, and nurse's aides, out of sheer necessity, be organized, strengthened, and put in charge of a single individual; further, that a balanced, effective training program encompassing all workers be developed and coordinated into a hospital-wide program.

"About the only thing they didn't know," commented Mr. Merritt, "was how we intended to accomplish these goals. Not every step was clear to me, but the concept was solid as a rock; it had to be an integration of administration, education, public relations. Even now, with training programs in session

(*Continued on next page*)

Dorothy Wallio is close observer of technic during a session on bed-making for new class of aides and orderlies. Prior to the accelerated program, turnover was very high among nurse's aides. Upgraded by better selection, training and working relations, attitude towards the job is further heightened by awarding of certificates only after aides have been on the job for a six-month period.

most of the year, and including every employee, we continue to revise and adjust in order to strengthen.

"In some ways we might be considered adamant; in other ways, flexible. We do not go along with those hospitals that urge their employees to 'come to the training program sessions if you can.' When a notice is issued this way, the nurse may use the well-being of her patients as an out, despite the fact there are others to care for the patients. We feel that participation is a way of growth, and growth is absolutely essential to all individuals if they are to realize their potential, or even anything approaching it. All classes are conducted on hospital time, and our feeling about attendance is well known. The fact is, results in other workers were so apparent and desirable, that laggards picked up their own feet in this regard.

"Ours is basically an *attitudes* program," continued Mr. Merritt. "We can train almost anyone in skills and technics; attitudes are more delicate to deal with in the early stages, almost indestructible in maturity. The basic reason for the training programs (we're trying to get away from the term 'inservice' because nurses consider it as one which applies to them exclusively, and ours is an over-all program) is to help develop more knowledgeable, capable workers in order to achieve better public relations.

"Personnel on the floor can give excellent care, resulting in a contented patient. But if the same patient is poorly treated at the cashier's desk when he leaves, that negative impression goes home with him. This, I sincerely believe, is where most hospitals fall down, in failing to realize that the impression is the sum total of many people and many things. If you are going to train a nurse's aide to give a relaxing, refreshing back rub, you had better be sure to train the laundry worker not to send up a gown with half the tie-fastener missing!

"People and public relations either complement each other, or they tear each other down. If concept and training have been instilled, we feel completely at ease that any employee's knowledge and manner will reassure a patient. Most deadly of all responses is 'I don't know; I've only been here two weeks.'"

In order to be at D&MC at all, an employee must have passed a physical examination, come through a tactful but straightforward discussion of home problems, if any, and a thorough investigation of references. Stability is probed, as much as an initial interview permits, and though it calls for restraint, applicants are not jumped at simply because a vacancy exists. The hospital prefers a vacancy to having a job filled inadequately or temporarily, unless there is no alternative.

By the time the new employee has been at the hospital two weeks, he or she has been through the general orientation for all employees (they are not separated by type of work at this point), and well into special orientation for individual departments.

The general, all-employee orientation, the first to be established by the training department, includes a welcome by the administrator; a history of the hospital; general information on its operation, including slides of various departments at work; personnel policies; advantages of employment; rules for patient safety in case of fire; public relations and patient confidence; organizational structure; a tour of the facilities; and a showing of the film, "The Patient Is a Person."

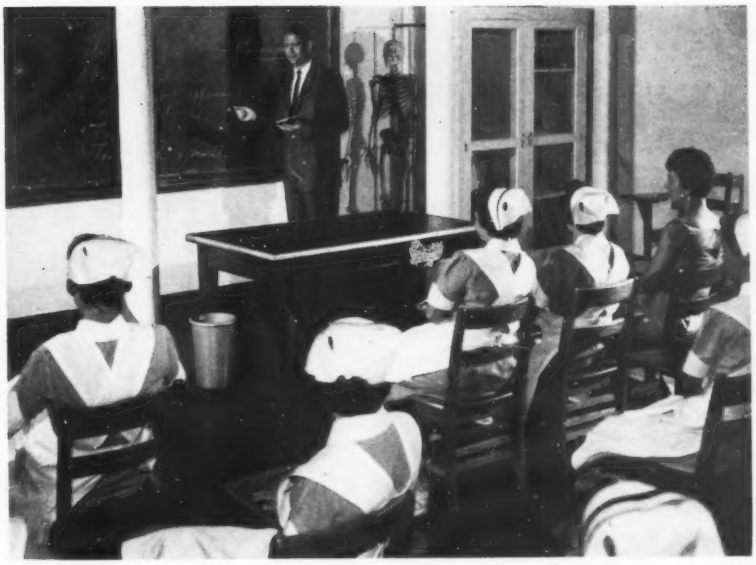
"It shortly seemed obvious," said Mr. Merritt, "that supervisors should know what employees were being told, so the second major undertaking was a supervisors' development program, aimed at answering questions collectively instead of individually. From there, the next step was into "What is a Supervisor"—covering what supervision should be, how the supervisor should function, and what the administration expects of him. It is a basic policy with Mr. Pullen that difficulties be ironed out at department-head levels, and these very informal, conference-type sessions have helped establish that pattern. The administrator presented some of the subjects, sat in on others, and absented himself—by request— from others, to encourage employees to speak more freely.

"Among the surprising things we learned," he continued, "was how little supervisors knew about personnel policies. They had printed copies, but they hadn't analyzed them. When they had questions, the old routine was to call personnel or administration to ask, 'How do you interpret this policy?' We tried to leave no doubt as to why policies were written as they were, and exactly what they meant.

"For this basic course, we divided some 70 supervisory personnel (all department heads, including head nurses) into three groups regardless of their work. Thus we might have graduate nurses, engineers, laundry, dietary and housekeeping personnel in one group. This mixing was deliberate, and proved most helpful in getting people acquainted with each other and each other's problems. By virtue of these sessions, the night supervisor was seen by the day people for the first time!

"One of our concerns with certain types of employees, generally the professional nurse," continued Mr. Merritt, "has been to eradicate this business of being 'different,' a notion instilled from early student days. We're making good progress here, aided by speakers from industry who point out that people aren't different; and that technics apply to people, not just to type of work or kind of business. My own relationship to specialty departments has been a long row to hoe, but if you can offer them service to help their own people, it pays off in the end. We have also seen a transition of first loyalty from 'my girls' or 'my crew' to the organization, where it belongs."

There is no set pattern for these classes. The department tries to run three sessions a year of one hour weekly for eight to 12 weeks per session. They do, however, cover standard subjects, including communications (the head of the speech department of Milliken University handled this, and films were also used); human relations; technics of management; evaluation of employees (what it is, how to do it,



Mr. Merritt conducts a class for senior student nurses on the principles of management. Faculty members of the school of nursing also participate in the training programs. Included in their curricula are orientation to the hospital, the school, the position, individual faculty members, and to the clinical services.

and how to use it); public relations; and discussion films on situations or case studies on getting along with others.

"We are currently re-doing these basic subjects," said Mr. Merritt, "from a different approach. When you do a program like this in a vertical grouping of people, you have a wide variety of knowledge and backgrounds to reach and challenge. This consideration was dismissed in our original courses in favor of bringing all types of personnel together.

"Now we feel a different grouping is indicated, so we are taking out those who are most proficient and who need more advanced challenges. We take a subject, such as the delegation of authority, and let one member of this group develop it and present it to the class. In another group, we are re-exposing the class to the same subjects, and letting the more proficient group do the teaching—a technic that helps both groups.

"We also have a group of 15 or 20 persons who are interested in forming a seminar, which we take as a stimulating progress note. Attitudes have very definitely improved all along the line, and when that happens, the hospital gets a bonus, because employees reflect the attitude of the supervisor. And if she is good, it's reflected more than it is if she is average or below par."

One of the staffing problems at D&MC was the turn-over in nurse's aides. "Girls used to come in who really seemed to want this type of job," said Mr. Merritt, "and according to the initial interview, they had no problem finding baby sitters, their husbands were all in favor of their working, etc., etc. The real facts didn't come out, it seemed, till after the aides had been trained and were working.

"We have a six-week course now, but are aiming for an eight-week or three-month course, long enough for screening while they are still learning and not in a position to hurt the organization if they drop out. We used to run nurse's aides programs every month or so because we lost them so fast. Now we do three a year, with better selection, training and working relations, and our turnover has dropped considerably. Also, we give the aide her certificate only after she's been *on the job* six months.

"Licensed practical nurses, of course, have the number of classroom hours set by the state, and they attend classes in theory in the downtown adult education center. Half of them receive their clinical experience here, the other half at St. Mary's Hospital. We pay them 50c an hour as a stipend while they are learning."

Specific and extensive orientation courses are currently given for registered nurses, licensed practical nurses, aides, interns, the faculty of the school of nursing, student nurses, junior auxiliary volunteers, supervisors, and new department heads, with others in the planning stage.

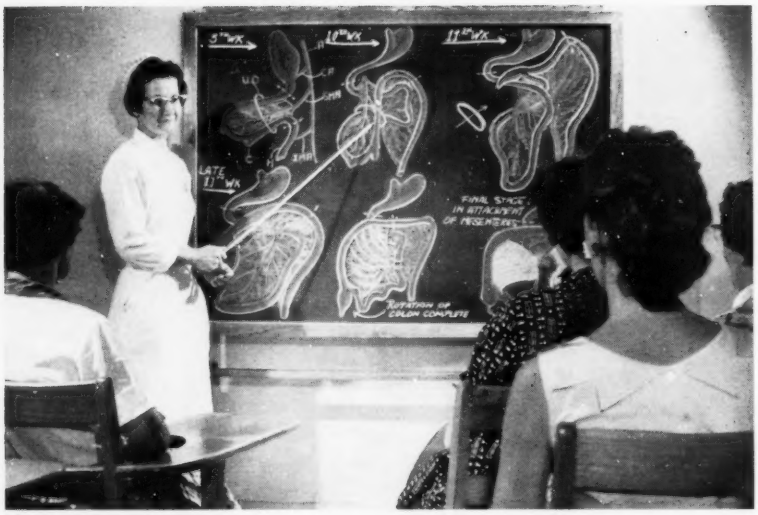
Space does not permit details of all these programs, but because of keen general interest in the subject, and the fact that at D&MC it involves more than 50 percent of the staff, or over 300 persons, TOPICS gives below the orientation course for registered nurses as typical of the thoroughness of the various courses.

I. Orientation for the registered nurse

A. General orientation

1. Meet director and assistant, nursing service
2. Meet area supervisors
3. Conference with "orienter"
   a. Supervisors – responsibilities and authority
   b. Head nurses
   c. Staff nurses
   d. Clinical instructor
   e. Student nurse
   f. L.P.N. and student practical nurse
   g. Technicians (technical aides)
   h. Nurses aides and orderlies
   i. Closely related departments – central supply,

(Continued on next page)



Mrs. Wallio leads a discussion class for medical records personnel in basic physiology and anatomy. Such training not only helps the staff become more familiar with the material with which they work, but stimulates interest in the subject and the need for complete and accurate record-keeping. One of the department members has been selected to attend school to become a registered medical record librarian.

x-ray, laboratory, admitting, food service, messenger service
j. Junior volunteer program
4. Tour of service departments and typical nursing unit

II. Hospital and nursing service policies

A. Conference with "orienter"
1. Review lines of authority
2. Review safety program
3. Discuss briefly and give copies of policies:
a. Accident reports
b. Barber and beauty service
c. Clinic patients
d. Coroner patients
e. Death
f. Disaster procedure
g. Emergency room
h. IV therapy and blood transfusions
i. Losses, thefts, damage to property
j. Male catheterization
k. Marking uniforms for laundering
l. Oxygen service
m. Public relations – release of information
n. Repair of equipment
o. Surgical-medical consent for treatment; abortion release
p. Telephone policies
q. Transfer of patients
r. Valuables – patients
s. Visiting hours – special visiting

III. Skills inventory and training

A. Conference with "orienter"
1. Discuss needs and understanding of procedures and equipment standards at D&MC
a. Blood pressure
b. Catheterization
c. Charting procedure
d. Irrigations – bladder
e. IV therapy and blood transfusions
f. Medications: IM, IV
g. Negative suction
h. Oxygen therapy
i. Water-sealed drainage (care of chest surgery)

B. Central supply and sterilizing – 16 hours
C. Recovery room (when needed)
D. Conference with area supervisor
E. Assignment to orientation nursing unit
1. General orientation to nursing unit
a. Introduction to all personnel
b. Tour of unit
c. Observation period
Nonprofessional personnel
Nursing secretary
L.P.N.
Nurse's aides and orderlies
Medicine nurse
Treatment nurse
Head nurse
makes assignments
makes rounds
orders medicine and narcotics
checks charts
copies orders
discharges
d. Supervised practice (when needed)
1. Assigned patients on case method
e. Assigned to regular floor duty
2. Check list to evening or night supervisor

IV. Follow-up

A. Evaluation sheet given to R.N.
B. Evaluation sheet returned
C. Conference with "orienter"

Graduate nurses attend the general orientation course for all new personnel. Conferences are then held with Mr. Merritt and his "faculty," consisting of Dorothy Wallio and Josephine Howard, both graduate nurses with degrees in education, to determine the individual's knowledge, past experience, and general outlook on nursing. Sometime during the first week, policies and procedures are gone over, and they have an appointment with the administrator, who expresses his opinions of what nursing should be in the hospital.

They are assigned to a teaching unit under the direction of a head nurse who has the attitudes and

skills the hospital wants imparted to new people. Either Mrs. Wallio or Mrs. Howard, and the head nurse, by observation and conference, determine the capacities of the individual and determine the length of her stay on the training unit before she goes into a staff position. This is true of all professional nurses, regardless of whether they are full-time or part-time, day or night shift. Standard orientation lasts two to three weeks, but is adjusted to the individual's abilities and the length of time she has been away from active duty.

When a special program is given for nursing, such as isolation technic, registered nurses, licensed practical nurses, and nurses' aides attend in a group. Originally there was some feeling about this mixing of the professional and nonprofessional because of the prestige angle. Not only has this disappeared, but participants feel that integration itself is helpful and instructive.

Mrs. Wallio and Mrs. Howard handle the major part of the teaching assignments, sit in on meetings of head nurses, handle orientation of R.N.'s, and conduct a workshop on the management of patient care for all graduate nurses.

Housekeeping has an annual program, twice a week for six months, in which its members are instructed, with the aid of films, in personal health and grooming, and the part they play in patient care and contentment. The cost of the equipment they use is emphasized, and salesmen demonstrate its use and care. There is a review of cleaning technics and of personnel policies. Public relations is stressed, and it is pointed out that three basic "do's" on their part can be a genuine contribution to public relations: get in, do the job, and get out. "Especially the getting out part," commented Mr. Merritt. "Lengthy gossiping by employees is not respected, even by those patients who would detain the workers longest."

The hospital has used county mental health clinic personnel to conduct sessions for aides and practical nurses and guide them in recognizing the emotional needs and aspects of patients.

Credit and admitting clerks have public relations sessions periodically, and programs for maintenance personnel, who thus far have had only the general orientation, are being planned.

Inseparable from the training programs at D&MC is administration's philosophy of operation. "We believe that personnel should do the work they are trained to do," said Mr. Pullen, "and not have superimposed on that job teaching and administrative duties, including the often overwhelming amount of paper work entailed.

"For instance, we have found nursing secretaries to be absolutely essential. More important, head nurses have come to the same conclusion – to the point that when a vacancy occurs, it constitutes a real emergency in their estimation. This is proof enough that head nurses were previously doing work they could ill spare the time for, and which can be performed equally as well by far less expensive nonprofessionals."

Recently, in line with this thinking, the hospital added a dietary department manager to the staff, who is responsible for the purchasing, cooking and serving of food. Dietitians are now free for their specialized job of planning proper menus, and visiting patients to instruct in special diets and to record – and follow through on – personal likes and dislikes. A formal training program is also in planning for the staff of this department.

The medical records department has just completed a course on terminology, including sessions in anatomy and physiology. It is Mr. Pullen's plan that the department itself be managed by a person with heavy supervisory background. "In a hospital of this size," he said, "a professional medical records librarian is absolutely essential, but management, again, goes back to personnel specializing in management. We have selected a young woman from the department who will attend school to become a registered medical records librarian, and we feel this combination of professional management and record-keeping will bring this department up to top-level caliber."

In professional nursing, the most sensitive nerve center in any hospital, the philosophy has come to receive unreserved backing. According to Oma Gardner, director of nurses, "the training program is functioning to help me, not to take away from my prestige. As long as we have people in a teaching capacity who know nursing, and as long as we have R.N.'s in the department who are able to do the teaching, I am very happy to be relieved of the responsibility. What has been established here is really an internship for nurses. We respect it greatly, and credit it with a sharp drop in nursing personnel turnover."

"The director of nurses," commented Mrs. Gardner, "must believe in inservice orientation and public relations. Some, unfortunately, take the short view and are anxious to get nurses out of orientation and into assignments, to the detriment of the individual and the department. Even the basically good nurse, deprived of training, will not function at her best level.

"We rotate all head nurses through the nursing office. This takes them off the floor for four weeks for sessions in budget, personnel, staffing, and other subjects. This training is invaluable to them, and gives someone back on the floor a chance to be in charge for a month."

"There is some controversy in the field about the philosophy that professional people are wasting their time on management, and we still have a long way to go before we can fully back up our confidence in this philosophy by hard facts and figures," said Mr. Pullen. "For some time past, we have been looking very critically at the nursing situation, where payrolls are heavy. We went into a study of methods and came to the decision to add an industrial engineer to our staff. We feel that whoever we choose to fill this position will help us achieve still further our very basic and strong desire to know exactly what we are going to do, and why, before we do it."

A lot of work pays off for the Lafayette (Ind.) Home Hospital as hospital personnel, guests, and visiting dignitaries break ground for a four-story (100-bed) patient wing. New wings for both Home Hospital and St. Elizabeth Hospital, Lafayette, have been made possible by funds raised in the HEALTH campaign.

Turning over first shovels of earth are (l. to r.): Dr. H. B. McAdams, president, Home Hospital medical staff; Dr. Martha O'Malley, director, hospital and institutional services, state board of health; Mrs. Floyd Wymer, president, Home Hospital auxiliary; Dr. C. H. Ade, vice-president, Home Hospital board of directors; Robert G. Brunger, president, HEALTH, Inc.; Franklin E. Simek, administrator, Home Hospital; Curwen Leaming, president, Home Hospital board of directors; and Dr. Russell J. Humbert, president, DePauw University.

Lined up for the camera just before the groundbreaking ceremony at St. Elizabeth Hospital are (l. to r.): Karl H. Kettelhut, general chairman, HEALTH campaign; Rev. John J. Flanagan, president, Catholic Hospital Association; Dr. Martha O'Malley; E. Joseph Bannon, president, St. Elizabeth lay advisory board; Most Rev. John J. Carberry, D.D., bishop, Lafayette Catholic diocese; Robert G. Brunger; Sister M. Mirella, administrator, St. Elizabeth Hospital; Dr. J. J. Stefaniak, chairman, HEALTH board of directors; and Sister M. Stephanina, assistant provincial superior, Mishawaka.

And taking part in the actual groundbreaking for a new 100-bed wing at St. Elizabeth are (l. to r.): Mrs. W. W. Washburn, president, St. Elizabeth Ladies' Auxiliary; Dr. Frank W. Ratcliff, president, St. Elizabeth medical staff; E. Joseph Bannon; Sister M. Mirella; Sister M. Stephanina; Dr. Martha O'Malley; and Robert G. Brunger.

Two Hospitals Raise $4 Million in Community Effort

Five-year-old Nancy Maris presents a tin box containing an assortment of small change to Karl H. Kettelhut. Nancy and 13 of her friends made clay ashtrays and figurines which they sold to raise money for the HEALTH campaign.

By Sister M. Mirella, and Franklin E. Simek*

When two community hospitals in the Lafayette (Ind.) area embarked on a united capital fund-raising campaign the local newspaper — *Journal and Courier*–called it "the most ambitious and pretentious fund-raising venture in the community's entire history." Just 14 months later the campaign had not only reached its $3 million goal, but had gone over that, to raise a total of $4 million on behalf of the St. Elizabeth and the Lafayette Home Hospitals.

When the campaign needs were first set forth–with an expectation of $1 million coming from the federal government under the terms of the Hill-Burton Act–serious doubts were expressed in many quarters that the $2 million balance could be raised. Behind this feeling of doubt lay the solid fact that in the recent past both hospitals had had great difficulty, on their own, in meeting much more limited fund objectives.

However, the need for a program to expand and improve the health facilities was abundantly clear. The population of the greater Lafayette area had risen to a new high of 55,000–a gain of well over 40 percent since the war years. As a result, occupancy of both institutions had on frequent occasions climbed well above the 100 percent mark. And, although both hospitals had at various times initiated improvements, no major construction or additions had been undertaken at St. Elizabeth since the early '20's, and none at the Home Hospital since 1928.

To decide on a comprehensive course of action a committee was composed of representatives from each hospital and leading citizens in the area. They were aided by the Greater Lafayette Chamber of Commerce and the Tippecanoe Medical Society. This committee took the first two steps: they called upon a nationally recognized hospital consultant and the state and local health authorities for a detailed definition of the needs of each hospital. This study and the architect's report, however, showed that if the hospitals were to anticipate more than just the

(Continued on next page)

At the victory dinner celebration for HEALTH are four of the men who spearheaded the successful drive for funds: L. to r. are Karl H. Kettelhut, general chairman for the HEALTH campaign; Robert G. Brunger, president of the HEALTH board of directors; H. G. Purdum, representative of Tamblyn and Brown, Inc.; and Dr. J. J. Stefaniak, chairman of the HEALTH board of directors and director of the campaign. Behind the men is the HEALTH rocket showing the total amount — $4,005,395 — raised in the campaign.

*Sister Mirella is administrator, St. Elizabeth Hospital, Lafayette, Ind.; Mr. Simek is administrator, Lafayette Home Hospital, Lafayette, Ind.

bare minimum health needs of the region a fund of at least $4.7 million would be required.

For the second step, the committee then called upon the fund-raising firm of Tamblyn and Brown, Inc., to study the problem of determining whether a major campaign could succeed. While sufficient sources of funds were present in the area, the firm's report found, contributions from all constituencies would have to reach maximum amounts for success in even the minimum campaign.

After a careful study of all findings, and because of the urgency for better health facilities, the decision was made. The hospitals, with the aid of the fund-raising counsel, would undertake a united capital fund campaign to seek the minimum $3 million amount.

As a preliminary move, a non-profit corporation, had been formed in early 1959. This group, which consisted of outstanding local citizens who represented the two hospitals, subsequently conducted the campaign. The group's name, HEALTH, Inc., was built from the first letter of each word in the campaign slogan—*H*elp *E*nlarge *A*dequately *L*afayette's *T*wo *H*ospitals.

This campaign – the largest ever to be conducted in these communities—raised $4 million. It was a campaign in which new levels of giving were established and which, according to the best information available, equalled or surpassed any other similar campaign in the state (and very probably in the nation as well).

Some significant statistics were found in analyzing the results of the campaign: over 25,000 individual gifts were received from citizens, industrial and business concerns, professional groups, the hospital families, organizations and foundations. In the solicitation program among industrial workers contributions equalled as much as $92 per employee—a record figure. And 192 corporation and employee groups qualified to be listed on the hospitals' honor roll by subscribing $40 or more per employee.

Following the public celebration and dinner a few weeks ago which marked the conclusion of the active phase of the campaign, Lafayette's newspaper (*Journal and Courier*) observed: "The greater Lafayette community has just experienced one of its most satisfying and significant accomplishments. Nothing even approaching this achievement, in a capital fund campaign, has ever taken place here. Courage, imagination and generosity were required to gain success. These qualities found abundant expression, along with hard work and persistence. Here are all of the ingredients for continued development and growth."

Particularly pleased with the results were members of the HEALTH board: Dr. J. J. Stefaniak, chairman of the board and director, Tippecanoe Laboratories, Eli Lilly and Company; Robert G. Brunger, president and superintendent, remelting division, Aluminum Company of America; E. Joseph Bannon, first vice-president and president, Purdue National Bank; Curwen Leaming, second vice-president and proprietor, Hazelwood Farms, Rommey, Ind.; Dr. R. B. Stewart, treasurer and vice-president, Purdue University; and Lowell C. Smith, M.D., secretary.

HEALTH board directors were: C. H. Ade, M.D.; Norbert Arth, president, Arth Drugs and University Drugs, West Lafayette; J. E. Bixler, president, Duncan Electric Company; Roger D. Branigan, attorney, senior partner, Stuart, Branigan, Ricks, and Schilling; Karl H. Kattelhut, general chairman for the HEALTH campaign and general contractor; James R. Price, chairman of the board of directors, National Homes Corporation; Burr S. Swezey, Sr., chairman of the board, Lafayette National Bank; Louis A. Weil, Jr., publisher, Lafayette *Journal and Courier;* Richard P. Gripe, M.D., vice-president, Tippecanoe Medical Society; and William J. Ishan, attorney.

At the victory celebration Robert G. Brunger, president of HEALTH, Inc., noted: "Several principal factors contributed to the success of this project. Of greatest importance was the whole-hearted enthusiasm for the HEALTH program on the part of the directors, the doctors, the hospital administrators, the general chairman, and the many volunteers and their complete readiness to accept and follow a prepared campaign plan set forth by fund-raising counsel.

"And," he continued, "of incalculable help in establishing the need and the urgency for the campaign was the decision on the part of Hill-Burton authorities in Indianapolis under the direction of Dr. Martha O'Malley to grant the HEALTH program a fund of up to $1.7 million when it could qualify on the basis of one dollar in federal aid for every two dollars raised."

The general chairman, Karl H. Kattelhut, stressed these aspects of the HEALTH campaign. "In my experience," he stated, "I have never seen any other group of men and women work harder or more devotedly in a community endeavor. To my knowledge no request to do a job was ever refused. In a number of instances committeemen stayed on the job until all hours in order to tell the HEALTH story to the night shifts in our industrial plants."

He added, "The success of this campaign will help to breed success for future community efforts. Methods learned and proven in this campaign, and the experience and the confidence we have gained from it, have put in our hands those essential tools necessary to assure the success of other community efforts. Our community has proved that it can be done."

In summing up, members of the HEALTH board made these points for their fellow citizens to reflect on. One said: "For the first time in a generation our citizens have been made fully aware of the needs of our hospitals and the day-by-day life-saving services they provide." And another said: "It is up to us to keep this interest alive by constant education and by providing as many ways of helping as possible."

But the *Journal and Courier* voiced the collective opinion of all the citizens in the area when its congratulatory editorial began: "A magnificent achievement."

Efficient Operation Keeps PT Out of the Red

By Mona Nelson

In contrast to some other hospital departments which are considerably more expensive to set up but fairly reasonable to operate, the physical therapy department's major costs are in its personnel and the nature of the physical therapy treatment.

In certain other sections of the hospital, i.e., the x-ray department, the major financial problem is the initial cost of setting up. After the department is in operation, it is relatively economical, and high volume of patients served adds to its income. It is difficult for the physical therapy department to pay its own way because of this personalized treatment of patients. The therapist may spend up to an hour with one patient, making the treatment extremely expensive to the hospital.

The key, then, is efficient operation—operation that serves the patient in the best possible personalized manner, and at the same time serves the hospital by paying—or nearly paying—for itself.

TOPICS visited the physical therapy departments of two prominent Chicago hospitals to get their views on operation of the department. These hospitals, both under ten years old, have physical therapy departments that went into operation the day the hospitals opened their doors. Both departments have had some of the same problems, yet both are now among the most efficiently run in the area.

(Story begins on next page)

Visitors pause in the lobby of Louis A. Weiss Memorial Hospital to view photo display created by the physical therapy department, showing treatments and equipment.

Resurrection Hospital

Efficiency in operation sometimes comes from unexpected sources, and is manifested in unusual ways, according to Mrs. Betty Horstman, head physical therapist at Resurrection Hospital on Chicago's northwest side.

"When we started, we had booth curtains of a dull tan material – serviceable, but drab. We requested, and got, the new pink curtains. Perhaps it's partly imagination, but we feel we're working more quickly and more cheerfully, and perhaps with a bit more enthusiasm. The patients seem more responsive, and often comment on the brightness of the department."

The department is presently staffed by two registered physical therapists – Mrs. Horstman and Rosemary Gloeckner, five full-time aides, and one full-time and one part-time orderly.

There are four treatment booths, as well as two whirlpools, diathermy, ultrasound, and electric stimulation apparatus, a gymnasium, and a Hubbard tank.

The broad hallway leading into the room set aside for the Hubbard tank has small, curtained dressing booths on either side, originally designed for outpatient use. "At first, we thought these special dressing booths were a good idea," explains Mrs. Horstman, "but soon discovered that patients using them would have to cross the busy room to the treatment booths wearing a hospital gown – a sometimes embarrassing situation. Now the patients dress right in the treatment booth, and we've pressed the dressing-booth space into service as an office and storage area."

In the first six months of 1960, the department treated 5,808 patients. In the comparable period during 1959, 5,037 were treated, and this growth has been characteristic of the department since its beginning.

The reasons for the growth are several. The location of the hospital itself is an important factor. Resurrection Hospital is located on Chicago's far northwest side, in an area presently enjoying a building boom. The hospital itself "grew" in a cornfield, and most of the homes which now surround the busy institution were not there when the hospital opened its doors in November, 1953.

Until Resurrection opened the area had no hospital facilities. The nearest hospitals were miles away in all directions. Since the area is one made up primarily of small homes, there are many families with young children. This shows up in the number of pediatric patients treated at the hospital and in the physical therapy department.

The steady increase in the hospital's patient load has contributed to the growth of the physical therapy section. Approximately 4,800 patients were treated in the PT section in the first year of the hospital's operation. In 1958, more than 10,600 were treated.

The department's load has steadily increased as the physicians associated with the hospital discover the many facets of physical medicine.

This discovery is not entirely accidental. The physical therapy department rarely misses an opportunity to bring itself to the attention of the staff physicians.

When the medical personnel have a general staff meeting, the head therapist often attends to explain a new system of treatment, or to acquaint the physicians with a new piece of equipment. At these meetings, the new equipment is often demonstrated with a patient's cooperation, so the physicians can determine for themselves the extent to which the treatment may be used.

One of the most effective ways to spotlight the new equipment, according to Mrs. Horstman, is to appeal to man's innate curiosity. "When the new piece arrives, we wheel it out into the hall and leave it there for a day or so. The doctors are just as curious as anyone else, and they begin dropping in to have the new piece explained."

The location of the department contributes to the workability of this last method. The entrance to the deparment is offset enough from the main traffic artery, so that a standing diathermy or ultrasound unit, or similar apparatus, does not constitute a traffic hazard. The department's entrance is directly off the hospital's emergency entrance, and near the staff parking lot, so that physicians entering the building can't help but see the new equipment.

At the present time, there are 10,000 positions open in the U.S. for physical therapists, and there is little likelihood that this situation will improve materially in the next few years. According to Mrs. Horstman, nonprofessional help must be relied on to alleviate the shortage.

In her department, there are four aides. While

these aides have had no formal university training in physical therapy, they are performing many of the functions of the trained therapist, always under the watchful supervision of one of the registered therapists.

Each of the aides is actually receiving an informal inservice training in physical therapy. While the more complicated treatments and exercises are reserved for the completely trained therapists, the aides are being trained in the use of most of the equipment involved in treatments.

Mrs. Horstman advocates formalized inservice training for the physical therapy aides. However, the department would be at a standstill if all the aides were instructed at the same time, so each individual is instructed at the time the new technic or treatment comes up. There are some treatments that must be reserved for the registered therapist thoroughly trained in physiology, kinetics, and other technical subjects, Mrs. Horstman emphasizes, but there are just as many technics that can be carried out effectively by someone without formal professional training.

The two orderlies in the department also perform some of the duties of the professional therapist. The full-time orderly has become the unofficial crutch expert. When a patient is ready to begin walking either with a walker or with crutches, it is the orderly who helps him take the first steps and slowly build confidence in himself.

The department's staff list must include Sister Margaret, who began her association with the department as a patient. A victim of paralytic stroke, she was treated in the department to help her regain some use of the injured left side, as well as strengthen the uninjured side. As an outgrowth of her treatment, she learned to use the typewriter one-handed, and, since the physical therapy department needed a person to help with charge tickets and other records, the happy combination of useful employment and continuing therapy began.

"She has been an inspiration to many patients, particularly stroke victims like herself," states Mrs. Horstman.

Department records consist primarily of two patient records and a charge form. Of the two patient records, one is a sheet made out by the department, showing the patient's name, room number, physician's

Therapy aides Linda Wallner (l.) and Gladys Jensen settle patient Burton Rissman into a traction rig. Therapy aides in the department are instructed in the use of much of the equipment.

name, diagnosis and history. There is space for date and type of treatment, and for progress notes. This record sheet is kept as part of the patient's permanent record and is attached to his chart. When an inpatient leaves the department, the physical therapy record accompanies him. Outpatient record sheets are kept in the department.

The second record, a file card, is kept in the department. Information on this card is a duplicate of that on the record sheet.

Treatment charges are billed through the hospital's centralized collections department. The charge ticket sent from the PT department contains the patient's name and other identifying information, as well as a notation of the treatment or treatments administered. The collections department bills the patient from a rate schedule.

The PT department treats 50 to 60 patients per day, between the hours of 8 a.m. and 4:30 p.m. The department was formerly open from 7 to 9 p.m. in addition to its daytime hours, but it has been difficult to obtain a registered physical therapist to supervise during the evening.

In 1953, the department's first year of operation, approximately 80 percent of those treated were orthopedic cases, fractures, and accident cases; the remaining 20 percent were stroke patients, arthritics, and persons with other chronic conditions. The percent-

(*Continued on next page*)

Left: Mrs. D. S. MacDonald, a member of Resurrection Hospital's auxiliary, cleans a whirlpool tank. Auxiliary members, as well as young "candy stripers," are regular helpers in the physical therapy department. Center: "Crutch expert" orderly Gino Melucci helps patient Terry Breslin get back on his feet. Right: While paper work demands much of her time, head therapist Mrs. Betty Horstman still can keep an eye on the entire department from her desk position. Window to right of desk opens on pleasant waiting room.

ages are steadily changing, with the chronic conditions now constituting about 40 percent of the total. This change in ratio is directly influenced by the lengthening of the life span and the increasing number of elderly patients.

Two years ago, in a further effort to render the work of her own department more effective, Mrs. Horstman obtained permission from the nursing supervisor to embark on an educational program for the nurses. Since that time, the program has been held twice yearly, for each of the nursing shifts.

Instructions are given in methods of moving a patient from bed to wheel chair and back again, the proper way to walk a disabled patient, and proper support of a patient.

Intensive instruction is given in proper bed positions for patients. The correct placing of sandbags for the support of a weak limb is emphasized, so that when the patient is admitted to PT, therapy to strengthen the weak limb can begin immediately, without the preliminary straightening of a limb allowed to relax in the wrong position.

The hospital's junior auxiliary aides each spend one day a week working in physical therapy. It is Mrs. Horstman's hope that some of the "candy stripers" will become interested enough in PT to enter the field. So far, five aides have entered PT training as a direct result of their association with the Resurrection department.

Just as the physical therapy department makes the most of what it has, so it teaches the patient to make the most of his own capabilities. "We're really only teachers," explains Mrs. Horstman. "All we can do is instruct, and the patient and his own initiative will take it from there. Most patients do not realize their own potential, and we must urge them to try new motions and new ways of making familiar motions."

Louis A. Weiss Memorial Hospital

Like many another physical therapy department, the PT section at Louis A. Weiss Memorial Hospital began by educating the staff physicians to the fact that the department was there, in operation, and ready to take patients.

Head therapist Doris Beemsterboer says that personal contact works best. Whenever possible members of the physical therapy staff discuss with doctors the benefits of physical therapy, the equipment and treatments available, and the general workings of the department.

To reinforce the personal contacts, an educational display was worked up, consisting of a pegboard containing photos of patients receiving treatments, and copies of the charts and forms upon which the department keeps its records. This display was first set up in the doctors' area, and later was modified and placed in the main lobby area for viewing by hospital visitors.

Miss Beemsterboer further increases the efficiency of her department by keeping an eye on the hospital's admission records. She is then aware of what patients might possibly be sent to her department and can thus adjust her staff and equipment schedules accordingly.

Members of the medical staff advisory committee inform other members of the medical staff of new equipment or treatments available in the physical therapy department. This is done at regular medical staff meetings. According to head therapist Beemsterboer, every opportunity to talk to the physicians is utilized, and the perseverance has paid off in increased cooperation from the medical staff and full utilization of the physical therapy department.

In the instance of the arrival of new equipment, generally the groundwork for its inclusion in the department is laid some time prior to its appearance. The doctors have been apprised of its coming, and by the time the new item is set up and ready, they are already requesting the new treatment for their patients. When one physician uses the new apparatus and gets

good results, others follow as the news is spread by word of mouth.

The department at Weiss Hospital is staffed by three registered physical therapists (including the head therapist), and two aides. The head therapist is responsible to the assistant director of the hospital. On professional matters she consults with the medical director. There is also a medical staff advisory committee for the department, composed of an orthopedist, an internist, and a general practitioner who has had much experience with orthopedic cases. At the time of opening about eight years ago, the full staff consisted of one therapist. The first year of operation saw about 800 patients treated in the department; the total in 1959 was approximately 8,000.

The three therapists handle an average of 35 patients per day. Most patients require more than one type of treatment, so that the number of treaments given may be two or three times the number of patients.

Part of the secret of the department's efficient operation, according to Miss Beemsterboer, is in the flexibility and tight scheduling.

The department's facilities are arranged in such a way as to take advantage of each square inch of space available. There are four treatment booths, each large enough to accommodate the treatment table and a piece of equipment. The equipment, rather than being stored in a specific storage area, remains in the booths. Thus, moving and shifting of equipment is cut to a minimum.

Walls between the booths are sliding curtains, so that in cases where more space is needed, two booths can become one. Aside from its convenience, the curtain-wall arrangement adds to the feeling of calm airiness which characterizes the department, and is enhanced by its cool green color scheme.

A fifth treatment booth can be arranged by curtaining off a corner of the gymnasium area. The curtains are permanent, hung from ceiling tracks. When the treatment area is not in use, the curtains are drawn back to the walls, leaving the gym area unobstructed.

Rather than scheduling patients, Miss Beemsterboer schedules the machines. "We used to schedule patients," she explains, "but if we set up a particular patient for, say, ten o'clock, it seemed that at ten o'clock that same patient might be in x-ray, his doctor might be with him, or some other hitch would arise, so that we would have an idle machine, or therapist, or both, for that treatment time."

Several methods were tried in an attempt to alleviate the situation, and the therapists finally arrived at the one now in use. Just before a booth is available, one of the aides is dispatched to the room of a patient for which the particular kind of treatment available has been prescribed. The aide brings the patient down in time for treatment. If that particular patient is involved with something else at the moment, the aide telephones the physical therapy department and is given the name and room number of another patient who can be treated. The aide then goes directly to the

Head therapist Doris Beemsterboer pulls curtains creating a treatment booth in a corner of the gymnasium. In this improvised booth, there is ample space for treatment table and equipment; when the curtains are drawn back to the walls, the gym area is unobstructed.

new room number and brings down the next patient. The therapist does not stand idle because the first patient was unable to come.

Inpatients are taken during the morning and early afternoon hours. Outpatients are treated during the hospital's visiting hours, when few inpatients can come to the department.

A streamlined system of keeping department records has been developed to eliminate time spent in complex bookkeeping.

Two separate patient records are kept, each containing essentially the same information. The first is a sheet recording the patient's name, room, physician, and diagnosis. This is made a part of the patient's permanent hospital chart. It contains space for the month and day of treatment, and for listing the physical therapy treatment given. There is also a space for progress notes. The physical therapy department's record sheet accompanies the patient to and from the department as part of his permanent record.

The second patient record is a 5x8-inch card kept on file at the department. This card also contains the monthly calendar form for recording treatment days,

(Continued on next page)

Mrs. Berta Hannusch, therapy aide, checks timers, kept near desk. Each timer is identified with a particular booth or whirlpool, and therapists can watch all treatment times from one location, rather than checking each booth.

Therapists Michael Gertz and Judy Bondurant check tally sheet of treatments at end of day. A running total is kept to facilitate end-of-period reports.

and space for diagnosis and history. The reverse side of the card is ruled for writing progress notes. The department keeps a card on file for each patient treated, both out- and inpatients. The record cards are filed alphabetically, and out- and inpatient cards are interfiled.

Inpatients requiring physical therapy, usually orthopedic cases, generally are in the hospital from one to three weeks. The record card allows enough space for about three weeks' treatments and progress notes to be entered.

Treatments are billed by the hospital's centralized billing department. Charge forms are made out by one of the therapists and sent to the billing department. One copy is kept by the physical therapy department.

In this charge form appears another successful efficiency measure. Before the present forms were adopted, each treatment was written out in longhand on the form—a long, tedious process. The new forms have the more common treatments printed on them, and the therapist merely checks those that were given. Unusual or special treatments are written out in a space allowed for them.

Perhaps one of the biggest time and work savers for the busy department personnel is the hospital's adoption of an Addressograph plate system, eliminating the many necessary handwritten entries of patients' names, numbers, doctors, and addresses. Upon admission to the hospital, an Addressograph plate is made up for the patient. When he is received at physical therapy, his embossed plate arrives along with his chart and records. It is a simple matter to insert the plate in the imprinter and print the information in the proper space on the form.

A simple, but complete, tally sheet is kept of the number of treatments and patients served each day. The purpose of this tally is to make end-of-the-period reporting easier. The Weiss Hospital operates on a four-week schedule rather than a monthly one. Each four-week period has the same number of working days and weekends, and facilitates both record-keeping and comparisons of one period with another.

At the end of each period, the head physical therapist sends a period report to the executive director. This report contains statistics on the number of patients treated, the number of new patients, and the number of treatments given of each type.

Before the invention of the tally sheet by Miss Beemsterboer, the administrator's report took hours to complete. All the records for the entire period had to be tallied at the same time, and the report written. Concerned with the time spent by the therapist away from actual treatment time, Miss Beemsterboer instituted the daily tally and the report form.

The treatments are listed on the tally form, and there is a space for each treatment each day. Statistics for the day are taken from copies of the charge forms kept in the department. Each treatment-day space on the tally is divided into two parts—another time-saving innovation by Weiss' head therapist. In the upper part of the divided space, the day's total of that treatment is entered. In the other half of the space, a running total is kept. At the end of the four-week period, even the totals are ready to be entered on the report.

The period report has been simplified to the extent that it is a ready reference. It is also a convenient form, requiring a minimum of actual writing, thus a minimum of the therapists' valuable time.

It is just as important to save time by efficiency as it is to save money. In a further effort to save the therapists' time, some treatments usually considered as the realm of the physical therapy department are now given by nurses on the floors. Modalities no longer used in the physical therapy department include moist pack treatments and Sitz baths. When it was decided that certain non-technical treatments, i.e., the moist packs, could just as easily be given by the floor nurses, members of the physical therapy department staff instructed the nurses in the administration of these treatments. Periodically, new members of the nursing staff are introduced to these treatments, and "refresher" lessons are given to regular members of the staff. If a problem arises with one of the treatments, the nurse in charge asks for, and receives, help from the therapists.

Storage is a problem in most hospital departments, and PT is no exception. When the Weiss department was opened, there was room for carts to be wheeled directly into the department and to be stored there. With the addition of equipment and personnel, and the increasing load of patients, the limited space allotted for desk work was taken over by treatment facilities and the desks were moved into what had been the cart area.

Weiss Hospital is in the midst of a construction program. The new addition adds some 31 beds to the hospital's capacity, bringing the total to 250. Scheduled to open in October, the new pavilion will house a second physical therapy department. This new department will be devoted exclusively to outpatient care, and will be staffed by two registered therapists.

The present department will also be expanded as far as space is concerned, although the staff will remain the same. When the new outpatient department opens, the patient load in the present department will drop. However, as more patients are admitted to the hospital, and as more physicians "discover" the physical therapy department, it is expected that the patient load will climb steadily until it equals, or exceeds, the present capacity.

Ident-A-Band®

When a person is sick, the right food can be as important as the right medication. And like a mixup in medications, a switch in food trays can endanger two patients.

Mixups need never happen when all your patients wear Ident-A-Band® by Hollister. Then you can be sure of each patient's identity, even if he is sleepy, disoriented or under sedation. Ident-A-Band offers *positive identification.* Just a glance at Ident-A-Band, a short "pause for patient identification," and you're sure the right patient is getting the right food tray, medication, test, or operative procedure. And Ident-A-Band is so soft and comfortable your patients will soon forget it's there.

®Ident-A-Band is the registered trade-mark of Hollister Incorporated.

Write for samples and complete information

HOLLISTER®
INCORPORATED

833 North Orleans Street, Chicago 10, Illinois

In Canada, Hollister Limited, 160 Bay Street, Toronto 1, Ontario

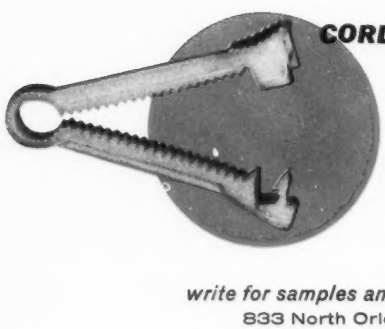
NEW

two W for OB

delivery room devices

PLASTIBELL disposable circumcision bell may be applied at birth in 2 to 3 minutes, minimizes chance of hemorrhaging. Eliminates later need for second room, nursing assistance, sterile pack. Hemostats and scissors are only instruments required. No dressings or post operative care needed. Bell drops off in 5 to 8 days leaving clean, well-healed line of excision.°

°*Kariher, D. H.; Smith, T. W. Immediate Circumcision of the Newborn. Obs. & Gyn., 7:50, Jan., 1956.*



CORD-CLAMP seals any size umbilical cord over safe quarter-inch area, eliminates hemorrhaging and seepage.† Easily applied with one hand, requires no tools. Maintains constant pressure as the cord shrinks. No belly band or dressings needed. Blind catch and serrated edges prevent accidental release or slipping. Nylon clamp is autoclavable and disposable.

†*Kariher, D. H.; Smith, T. W. Personal correspondence, 1959.*

write for samples and literature
833 North Orleans Street
Chicago 10, Illinois

HOLLISTER®
INCORPORATED

Planning the Food-Service Facility in a Convalescent Hospital

By Christine Pensinger, F.F.E.S.

When the plans were first drawn for the 65-bed Bonnie Brae convalescent hospital, which opened its doors in Los Angeles August 15, the owners left it up to the architect to plan the food-service facility. Before building started they realized that the kitchen as planned could not be operated efficiently with a minimum amount of labor. The services of a professional food-service equipment consultant were obtained to redesign the kitchen area.

The area set aside by the architect for the food service was very small, but at that late date, even on a new building, it was necessary to get the needed equipment in the given area.

Inconvenient location of storage space and lack of a sufficient amount of it were two problems which required solutions. The original plans showed the storage area located at the far end of the kitchen, so that every time a delivery was made the man had to roll his truck through the working section of the kitchen. This problem was solved by relocating the storage area near the delivery entrance.

To make up for the inadequate amount of space allocated for storage, mobile storage cabinets were designed which could be moved directly to the cook's work section.

Reach-in refrigerators were used with upper and lower doors. The interior specifications provide for a maximum use of space.

Inventories on food and kitchen supplies should be kept at a minimum in hospitals where it is possible to get daily deliveries.

The kitchen is air-conditioned, with small windows, which do not open, located near the ceiling to provide natural light. No wall space is wasted with windows; neither is there any large expanse of glass to be kept clean.

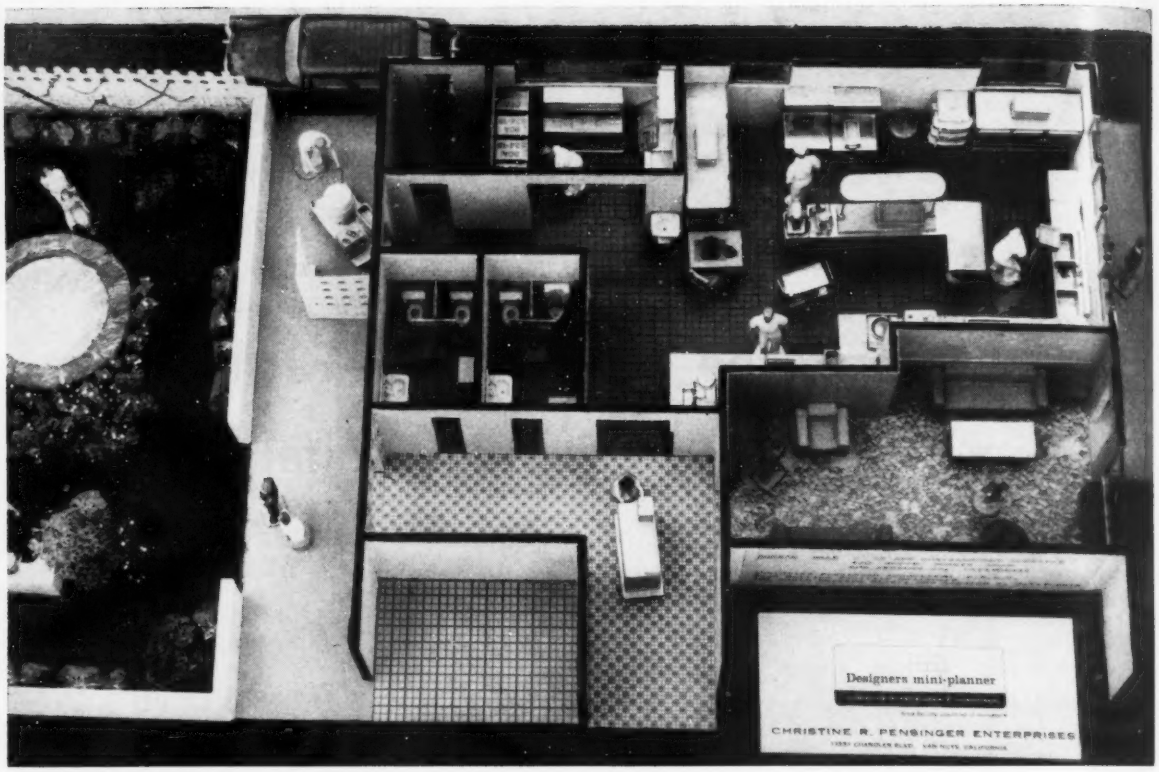
The kitchen will be operated by a cook-manager, with two other employees. The equipment and its placement have been designed for a minimum amount of labor. A staff of trained dietitians from a professional dietetic service will act as supervisors of the entire food service, planning menus, furnishing standard recipes, and being available for consultation with the doctors on all special diet problems.

From a business standpoint it is not practical for a small sanitarium or hospital to employ a full-time dietitian. Through the dietetic service trained dietitians are available at all times. The service is contracted for on a year's basis, and it costs just a fraction of the cost of a full-time dietitian.

About 50 percent of the patients will be ambulatory. Meals will be served to patients in their rooms. A combination dining-room and lounge has been provided for the staff.

(*Continued on next page*)

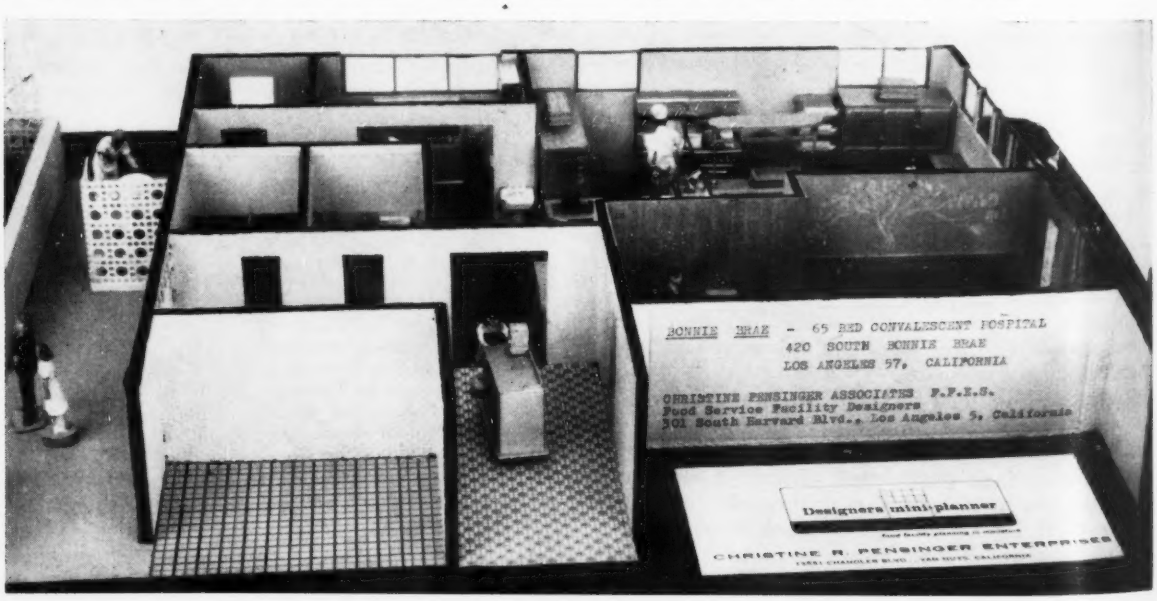
The author, a food-service facility consultant, heads the Los Angeles firm of Christine Pensinger Associates. She specializes in designing and setting up the operation of the food-service facility for hospitals and retirement homes. Before forming her own firm she served as director of nutrition for the State of Illinois, food consultant for Marshall Field & Co., Chicago, and food and equipment consultant for Wear-Ever, Aluminum Corp. of America. The "F.F.E.S." after her name stands for Food Facility Engineering Society, of which she is a member.



Above: In the small convalescent hospital the cook manager must have his desk and phone near the cooking area, the author emphasizes. The desk is shown in the center of this picture. To the left of it is the hand sink and the drinking fountain which Mrs. Pensinger says is a must from a sanitary standpoint, even in the small kitchen. Model even includes miniature employees, shown at their work stations. At right, worker washes large pan at three-compartment pot sink. The small 4' table back of him is mobile so that it can be used as part of the make-up table when meals are served. Enclosed patio is at left in photo.

Below: Accurate visualization of how the kitchen would look and function was made possible by use of a "Designer's Mini-Planner," a quarter-inch-scale model, developed by Mrs. Pensinger and first used in designing the Walt Disney Studio kitchen. After this three-dimensional model of the Bonnie Brae kitchen was approved by the hospital's owners and operators, the architect began the working drawings of the food-service facility.

The food-service facility is small — designed to operate efficiently with a minimum number of employees. Combination lounge and dining area for the staff is located next to kitchen (right foreground in picture). Note mural painted on the wall. If at a later date it becomes necessary to expand the kitchen, this area will be available.


BONNIE BRAE - 65 BED CONVALESCENT HOSPITAL
420 SOUTH BONNIE BRAE
LOS ANGELES 57, CALIFORNIA
CHRISTINE PENSINGER ASSOCIATES F.F.E.S.
Food Service Facility Designers
301 South Harvard Blvd., Los Angeles 5, California
Designers mini-planner
CHRISTINE R. PENSINGER ENTERPRISES

Food is delivered to the patients in hot and cold food carts, and served in attractive plastic dishes similar to those which they might use in their own home. Plans call for a selective menu for all patients.

As more bed space becomes available, prospective patients will do more "shopping around." The reputation of a hospital in a community can be made on its good food. The hospital which can offer a variety of tasteful, well-prepared, attractively served food will have no trouble in operating at full capacity.

Bonnie Brae answers a definite need in Los Angeles for "in-between care." Quite often a doctor would release a patient from the hospital if he could receive nursing care in his own home, but this is difficult and expensive to secure.

Though patients of all ages will be admitted to this convalescent hospital, it is expected that most of them will be older persons. Patients will be admitted directly, upon recommendation of their doctors or by the various hospitals. They may enter for a limited time – coming directly from an operation in a nearby hospital – or for a longer period.

There is a well-equipped, modern physical therapy department with a registered physical therapist on 24-hour duty. The patient can receive treatment in his own room or in the department.

The Bonnie Brae is an attractive, English-type, one-story structure designed in a U-shape, with a beautiful enclosed patio in the center – a restful place for ambulatory patients to gather and entertain visitors. The patio is completely paved for sanitary reasons and also to reduce maintenance to a minimum. The exterior of the building is attractively landscaped, and it looks more like an exclusive apartment building than a hospital.

Leslie Grant, the administrator and part-owner, has for the last 15 years been an executive in nursing homes and sanitariums. Another owner is Jim Geddes, who has operated a sanitarium registry service in the Los Angeles area for 20 years and has made a detailed study of the facilities in the more than 2,000 sanitariums in the Los Angeles area. The third owner, Mrs. Harwood, has been operating her own sanitarium for more than 17 years.

Robinson Wins TOPICS' Editorial Contest

Winner of this year's HOSPITAL TOPICS' editorial competition is Edward P. Robinson, administrative assistant, The Western Pennsylvania Hospital, Pittsburgh, with a report on "Determining Nursing Staffing Patterns in an Intensive Care Unit." Mr. Robinson has been awarded the $100 first prize in this second annual editorial competition for hospital administration graduate students.

All articles were evaluated on the basis of a point scale, with the following breakdown:

1. *Writing of manuscript*	10 points
2. *Organization of manuscript*	10 points
3. *Importance of and current interest in subject matter*	10 points
4. *Original technical research and work*	25 points
5. *Completeness of coverage*	10 points
6. *Originality in dealing with problem*	10 points
7. *Constructive new ideas or value of findings or recommendations*	15 points
8. *Contribution to the literature*	10 points
Total	100 points

With a high score of 89 points, Mr. Robinson's paper was judged "an excellently written, well-organized technically competent article." His subject matter is "of importance and current interest . . . a real contribution to the hospital literature."

The article is scheduled to appear in an early issue of HOSPITAL TOPICS.

Second prize – with an award of $75 – went to Garrett R. Graham, administrator, The Lynn Hospital, Lincoln Park, Mich., for his "Establishment of an Inventory Control System of Capital Items for Saginaw General Hospital." The judges characterized this paper as "the best, concise step-by-step statement on how to meet an important problem of administration. It is excellently and simply written and well-organized."

Mr. Graham's paper, with illustrations, is also slated to appear in TOPICS.

The third prize of $50 was won by James S. Urda, administrative resident, The Delaware Hospital, Inc., Wilmington, Del., for his paper on "The Hospital Viewed as an Organizational Synthesis of Change, Complexity, Conflict, and Coordination," which the judges termed "an excellent statement of why's and wherefore's of hospital problems." This article too will be published in TOPICS soon.

Honorable mentions were awarded to two other papers: "What the Public Thinks of Hospitals," by Harold E. Josehart, administrative resident, Butterworth Hospital, Grand Rapids, Mich.; and "What Can an Employee Morale Survey Contribute to Hospital Management?" by Virginia E. Jones, Northwestern University school of hospital administration. Both articles will appear in TOPICS.

The editorial competition is held yearly to promote high standards of professional writing and individual research, and to give recognition to schools and students of hospital administration. All academic and resident students of the recognized graduate schools are invited to participate. Deadlines and rules for the 1960-61 contest will be announced in an upcoming issue of HOSPITAL TOPICS.

INSTITUTIONAL SANITATION

By Howard Cadberry*

Because of the increase of hospital infections in the last few years, there is a need for an increased understanding of the basic principles of effective sanitation. If the spread of resistant infection cannot be checked, the physicians are going to have to relearn a lost art – how to fight infections without modern drugs.

The objective of sanitation is easily stated, but difficult to attain. The goal is to provide a psychologically attractive, physically clean and bacteriologically safe environment for people. Note that there is no mention of cost – there's the rub! Dirt and filth are frightfully expensive. In a well-run factory, it costs about $65 per pound to mop up dirt off the floors. A pound of dirt on an airplane costs $50 to remove and at least $100 a year to haul around.

In hospitals, surface soil probably costs over $100 a pound to remove. A large, well-run ward should not yield over one ounce of dust or soil, but this ounce can contain over ¼ million organisms.

At least 90-95 percent of the cost of cleaning and disinfecting represents labor cost. So the dubious economy of using cut-rate materials and equipment should be obvious. If costs have to be pared, one should look first at ways of increasing efficiency as measured by the area a workman can effectively cover in a given time. There is much need for new equipment to speed up and simplify the job of institutional sanitation. Further, like safety, sanitation is everyone's business, but someone must exercise centralized authority. If top management does not back the housekeeping and sanitation program, it can never be made successful from the worker up.

An operation that may represent upwards of five percent of total operating cost should have a responsible director with authority to carry out an efficient program. "The management of a cleaning program involves direct supervision of cleaning activities, worker training, purchasing of supplies and equipment, accounting and inventory control, planning and scheduling of cleaning, and evaluation of cleaning needs and performance. These duties require more than a head janitor! An administrator of considerable ability should be provided with broad authority to keep the plant as clean and sanitary as possible at the lowest reasonable cost."[1]

The targets of institutional sanitation are generally two in number: the *air* and the *surface of objects.* Food, water, and drug sanitation are outside the scope of our present consideration. Around this surface versus air concept has clung a considerable controversy as to which was the more important. The goal is to minimize the chance of cross-infection. But, while enteric infections are largely transmitted by direct or indirect contact, respiratory diseases can be contracted from direct infection or by the aerial route in one or more of the following ways:[2]

1. *Droplet infection,* implying direct impingement of the ejected infective matter upon the mouth, open wound, etc.

2. *Infection by droplet nuclei,* implying inhalation of the minute residues of evaporation from droplets, which because of their small size and lightness, remain suspended in the air for some time.

3. *Infection by contaminated dust,* representing the "secondary reservoir" of infective particles which accumulate on the floors, blankets, etc., and may become resuspended in air, especially after some mechanical activity such as sweeping or walking.

There is constant interplay and interchange of infective matter between the *carrier,* the *air,* the *floor and bedclothes, objects in the room* and the *victim.* This is diagrammatically represented in Fig. 1.

For this reason, it is important to remove most infective particles from the air. Some years ago the major attack was on the air itself. Ultra-violet lamps, [3,4] glycol vaporizers, etc., [5,6,7] were in vogue. Then came the oil bath, oiled floors, [8,9] oiled blankets, and draperies. [10,11,12,13] Currently the emphasis is on surface disinfection. Sanitize the floor, the table and the objects in the room and trust that removal of "secondary reservoirs" will minimize air contamination. There is no reason why we should be slavishly addicted to any single technic which happens to be the present fashion. The objective is to get *results,* not necessarily to follow a prescribed routine.

Methods

The surgery, the nursery, and the patient rooms or wards deserve special treatment. The public areas in institutions sometimes are sparingly disinfected. The methods used are doubtless so familiar that detailed mention is unnecessary. Wet mopping, canister care, washroom procedure, waste handling, bedding changes, and the swabbing of furniture are all aimed at minimizing the spread of infective matter, and should be properly designed to protect the sanitation person-

*Head, Industrial Chemistry Section, Midwest Research Institute, Kansas City, Mo.

principles and technics

nel. These procedures can be designated as *routine, terminal* or *isolation technics*, depending on the nature and severity of pathogenic contamination encountered. Most equipment and chemical suppliers are only too eager to furnish detailed regimes for the use of their products.

Measures

Assuming you have adopted a system for routine and special sanitation, how do you know if it is successful? The work on germ-free animal-colony raising at Notre Dame University has provided some of the best methods for measuring the degree of freedom from contamination. Most authorities are in favor of actual use checks. These can involve both surface "swab-rinse" [14, 15, 16] counts and air sampling for organism population.

A recoverable surface count of 100 viable organisms per 4-sq-in. area with no more than one percent pathogens indicates that floors, utensils, and so forth, are well disinfected. Air counts are more variable, but comparative values will serve as a good check on both disinfection and dust-control measures.

If it is not possible to run routine checks on the efficacy of disinfection procedures, then the less desirable method of comparative statistics must be used. Since the objective is to cut down cross-infection, one should look to the nursery as a sensitive indicator of the whole institutional sanitation level. The infants presumably come into the delivery room without benefit of external pathogens, and without acquired immunity. The infections infants pick up during their nursery stay rather accurately reflect the care taken in protecting the hospital environment. In fact, the very sensitivity of the nursery has led to the almost universal establishment of semi-isolation procedures.

However, spectacular results can be achieved in "rooming-in" hospitals *if* the disinfection procedures are most scrupulously observed. [17, 18, 19] Not a single case of infection was observed among 912 babies in the "rooming-in" division of Lebanon Hospital during the four and one-half years since the inception of rooming-in. [17*]

With this general look at the objectives, targets, methods and measures of sanitation, let us turn to the chemical materials employed.

*The absence of crowding with its accompanying hazard of cross-contamination, is also an important factor in the reduction of infection in such units.—*ED.*

Detergents

First, there are the detergents. Contrary to what you have heard, you *can* disinfect a dirty surface – but don't try it! For any reasonable sanitation technic, the chances of success are reduced 50-100 fold if the surface is dirty. Thus, effective detergents are the backbone of institutional sanitation.

The detergent materials employed include alkalies, surface active agents, and detergent auxiliaries such as water conditioners.

Most of the common detergents are mildly alkaline, about pH 10.5, and, on most surfaces, are satisfactory for cleansing away soil, grease, mucus, and other foreign materials.

Neutral detergents are generally preferred for delicate or sensitive surfaces but seldom are as effective as the alkaline compounds in cutting through heavy contamination. True, neutral detergents minimize the necessity for thorough rinsing, but rinsing is desirable if properly carried out. The three steps of *scrub, rinse* and *dry* are the best assurance of clean, streak-free surfaces.

A valuable technic called "alternate cleaning" can be adopted from the food industries. This procedure involves the use of alkaline detergents for surface cleaning on several days, followed by the use of a

(Continued on next page)

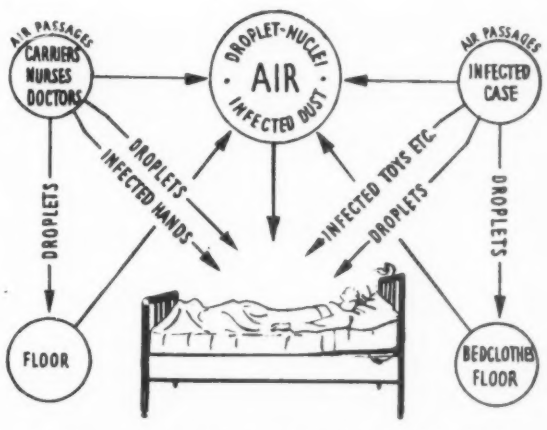


Fig. 1: Diagram of interchange of infective material in the hospital environment.

mildly acid detergent at selected intervals. This prevents the build-up of surface film or scum, which may eventually coat the surface if alkalies are used continually. In using this procedure, one should follow the manufacturer's instructions both as to scheduling and concentrations used.

The synthetic surface active agents are well established as superior to soaps. It is claimed that nonionic detergents (of the high foaming type) are effective cleaners on more surfaces, and for more soil types than are the older, anionic agents. [20, 21] Certainly a properly formulated, built nonionic is an effective cleaner that lends itself to versatile use, and does not destroy the effectiveness of germicidal agents.

Do not be misled about synthetic detergents. The fact that they do not cloud or scum in hard water does not mean that they are unaffected by water hardness. Tests show that even Kansas City tap water at 90 ppm hardness considerably reduces the cleaning effectiveness of detergents compared to fully softened water. [22] In hard water areas one should use either a detergent specifically designed for hard water effectiveness or a separate softening treatment for scrub water. Resin type, ion-exchange softener systems are most preferable, but detergent auxiliaries such as the EDTA softening tablets are a satisfactory compromise.

Disinfectants

It is in the field of disinfectants that the greatest controversy and misunderstanding occurs. The types of germicidal agents generally encountered can be classed as:

TABLE I

Results Obtained with Selected Commercial Germicides of Different Types in the Phenol Coefficient and Use-Dilution Confirmation Tests[16]

Germicides By Type	Phenol Coefficient (S. typhosa at 20°C)		Use-Dilution Confirmation Tests*	
	Claimed	*Found*	Max. Safe Use Dilution (*C. cholerasius*)	Max. Safe Use Dilution (*M. pyogenes var. aureus*)
Pine Oil				
1	5.0	5.0	1:100	Undiluted
2	3.0	3.0	1:60	1:5
3	5.0	5.1	1:100	Undiluted
4	5.0	4.7	1:100	1:5
5	4.0	4.2	1:80	Undiluted
Pine Odor				
1	5.0	5.0	1:5	1:5
2	3.0	3.0	1:60	None
3	5.0	5.0	1:100	1:5
4	5.0	5.0	1:100	None
5	5.0	5.0	1:20	1:100
Phenol Emulsifying Type				
1	5.0	5.2	1:40	1:20
2	5.0	5.0	1:100	1:20
3	5.0	4.7	1:80	1:20
4	5.0	5.2	1:60	1:5
5	5.0	5.0	1:40	1:80
6	32.0	36.0	1:640	1:640
Phenolic Soluble Type				
1	4.0	4.0	1:80	1:40
2	4.0	4.2	1:80	1:80
3	5.0	6.7	1:100	1:80
4	4.0	4.4	1:80	1:80
Quaternary Ammonium				
1	25.0	25.0	1:100	1:100
2	20.0	22.2	1:50	1:50
3	25.0	23.3	None	None
4	5.0	5.0	1:5	1:5
5	25.0	25.6	1:60	1:60

*The maximum dilutions tested were no greater than those indicated to be safe by conventional calculations using the phenol coefficient claimed.

1. Pine oil disinfectants
2. Chlorine and hypochlorites
3. Phenolic compounds
4. Quaternary ammonium compounds
5. Mercurials, organic and inorganic
6. Oligodynamic metals
7. Iodine compounds and complexes
8. Miscellaneous agents.

The number of agents in each class and the confusing results reported make generalizations risky. So before discussing the merits of individual agents consider:

1. Label information
2. Disinfectant testing
3. Requirements for a hospital disinfectant.

Labeling

Germicidal agents sold interstate are required to be registered with the U.S.D.A. under the Federal Insecticide, Fungicide and Rodenticide Act. The following information is compulsory, and *must* appear on every label.

1. **Name and address of manufacturer**
2. **Name, brand or trademark under which sold**
3. **Net contents**
4. **Statement of ingredients**
5. **Appropriate warning or caution statements**
6. **Use directions.**

The last item, the proper use of directions, can optionally be given in so-called "labeling" which can include pamphlets or booklets accompanying the package.

Thus, for the user the label should provide detailed and accurate information regarding the contents, the active ingredients, special precautions, chemical compatibilities, and most important, the proper dilution and procedures recommended for: (1) general disinfectant uses; (2) disinfection of surgical appliances and instruments; (3) special anti-fungal uses; and (4) antiseptic uses.

Note that the phenol coefficient is *not* required on the label. If it happens to be given, the best thing to do is to disregard it. Phenol coefficients on labels are more apt to mislead the user than to help him.

The thing that is wrong with most labels is that they are not carefully read and followed. The user should follow the use instructions provided by the manufacturer rather than calculating his own.

Testing

The accurate testing of germicidal power is almost impossible. The principal factors which confuse the testing include concentration, time, temperature, volume, the test organism used, the presence of protein, pH, surface tension, mechanical scrubbing, and ionic equilibrium. For many years the Rideal-Walker procedure was used to compare the potency of agents relative to phenol. The method is still used with certain modifications, but now it is recognized that the term "phenol coefficient" is more misleading than helpful.

It was originally intended that five percent carbolic acid be used as a standard of known efficacy for killing *S. typhosa*, and that the dilution necessary for a product to equal this standard could be obtained simply by multiplying the phenol coefficient by 20.

This only works, however, if the agent is chemically similar to phenol and acts to kill germs in the same way as phenol does. It is dangerously misleading to use this simple calculation of use dilution on chlorine, iodine, mercurials, pine oil, or other agents radically different from phenol.

It cannot be accepted, as has been commonly assumed, that germicides used at dilutions equivalent in efficiency against *S. typhosa* to five percent phenol at 20°C. in the phenol-coefficient method will possess reasonable margins of safety for the destruction of infective organisms. The cleaning processes used on floors, walls and equipment are often of a superficial nature and cannot be relied upon to reduce the amount of interfering organic matter sufficiently.

Therefore, many germicides do not kill infective organisms at 20 times their phenol-coefficient values. This variable behavior of commercial disinfectants is shown in Table I.[16] It can be seen that some agents are safe at dilutions computed from phenol-coefficient values, but many are not safe.

Two of the major factors which confuse the measurement of germicidal activity are bacteriostasis and inactivation. Those agents which temporarily stop the growth of organisms give falsely high values. So do the compounds whose power is destroyed by proteins or other organic matter.

There are three principal ways of testing germicides more realistically. These are *test tube methods, animal tests,* and *use tests.* Practical conditions can be simulated in the test tube by drying the inoculum on the test surface and measuring the kill in the presence of serum, cystine, or thioglycolate. Another way is to treat the test organism with the germicide and then inject a small amount into a rat's tail. The useful dilution is the highest one that protects the animals. Finally, the product may be tested in use: for example, in sterilizing deliberately contaminated surgical scissors. For greatest security, a profile of germicidal activity in a whole series of test procedures is the most useful.

Because of the confusion resulting from the phenol-coefficient determination, the U.S.D.A. has adopted the "use-dilution confirmation test"[16] to calculate recommended use strengths. A product whose recommended use-dilutions fail this test may be considered misbranded.

From consideration of the conditions of use and the performance desired, sensible disinfectant specifications covering these products can be set up. Klarmann [22] and others have outlined useful specifications for purchasing institutional disinfectants. Such specifications can be based on a combination of tests, some made in the presence of 10 percent horse serum, and may include:

1. The AOAC phenol coefficient against *S. typhosa* and *Micrococcus pyogenes var. aureus*
2. The AOAC use-dilution confirmation test with the same organisms

(*Continued on next page*)

3. The AOAC fungicidal test against *Tricophyton interdigitale*

4. The use-dilutions found to destroy *M. tuberculosis, E. coli, Pseudomonas,* hemolytic streptococcus, pneumonia, diphtheria and dysentery organisms.

These tests, together with specifications covering solubility, pH, odor, stability, toxicity, irritation, and residual action, help to define the requirements for a modern disinfectant.

The importance of an agent which remains bactericidal on the surface to which it is applied should not be overlooked. Thus, a modern disinfectant can be described as having:[2]

"Demonstrable, true, nonspecific effectiveness against the most resistant of respiratory and enteric pathogens. Activity against fungus, virus and spores is desirable. Other things being equal, an agent which offers a lasting antimicrobial blanket is deemed preferable to one having short-term effectiveness, no matter how pronounced."

Now let us examine the individual and class characteristics of various germicides.

Pine oil disinfectants are not capable of killing micrococcus. This, together with their odor and tendency to streak, makes them more suitable for public washrooms than for critical uses in hospitals.

The hypochlorites and related products are low-cost, fast-acting, broad-spectrum agents for use in sanitizing already *cleaned* surfaces. The activity is largely lost in the presence of soil and organic matter. There is no residual action.

Mercurials, both inorganic and organic, are pronounced bacteriostats and can be partially inactivated in the presence of blood or organic matter. While they are frequently advocated for "cold sterilization" because of their sporicidal action, recent evidence has shown them to be generally ineffective under practical conditions.[23, 24]

The oligodynamic metals, such as silver and copper preparations, are slow in action, largely bacteriosatic, and tricky to use. But they are outstandingly mild and extremely persistent in their residual activity when absorbed on either hard surfaces or textiles. Silver sols are of some use in treating drinking glasses and carafes, as well as rendering dressings and linens residually germicidal.

Quaternary ammonium salts as a class vary considerably in their ability to deliver, at use-dilution, the potency promised by simple test-tube evaluation methods. The products are good deodorizers and are noncorrosive. Some skins are sensitized by repeated contact. The products are inactivated by soaps and by most hard waters. Used as a final rinse, many of these "quats" provide residual activity on textiles such as diapers.

Iodine preparations, especially the non-ionic iodiphors, are especially noteworthy because of their nonselective, broad spectrum of activity. The products are fast-acting, noncorrosive, and nonirritating and are fairly good detergents. The residual activity is prolonged for several days, and the color of the solution provides an indication of the depletion of activity.

Because iodophors inactivate spores, viruses, protozoa, fungi and yeast spores as well as resistant bacteria, they are particularly useful for isolation and terminal disinfection.

Phenolics take us back to the time of Lister, but still are among the most satisfactory germicides. Modern phenolics based on substituted or chlorinated phenols are mild in odor, and nonirritating. They have prolonged residual activity. In actual use they deliver the killing power indicated by laboratory tests. Phenolics kill fast, and are effective against most resistant organisms.

However, it must be emphasized that the materials used in sanitation can be no better than the care taken by the people who use them.

Only by a return to rigid sanitary procedures can our institutions prevent the spread of infection. Implementing the more drastic program of sanitation necessary for better infection control requires four steps on the part of an enlightened management:

1. Decide on realistic objectives to be accomplished.

2. Design a scheme of procedure that will insure adequate and frequent coverage of all target areas. Use the best equipment available.

3. Set up strict specifications for disinfectants and select materials on the basis of a wide profile of modern test methods to meet your actual requirements at reasonable cost.

4. Measure the degree of accomplishment of your objectives by on-the-spot tests of surface and air contamination.

REFERENCES

1. Gadberry, J.M.: "General Industrial Cleaning." *Industrial Detergency,* pp. 281-282, Reinhold (1955).
2. Klarmann, E.G.: "Surface Disinfection and Respiratory Ills." *Modern Sanitation,* 6, p. 17, June, 1954.
3. Willmon, T.T.: "A Review of a Four-Year Experience with Ultraviolet Irradiation and Dust Suppression Measures, 1943-1947." *Am. J. Hyg.* 48, p. 227 (1948).
4. Hamburger, M.: "The Effect of Triethylene Glycol Vapor on Airborne Beta-Hemolytic Streptococci in Hospital Wards." *J. Inf. Dis.* 76, p. 208 (1945).
5. Puck, T.T.: "The Combined Action of Glycol Vapors and Dust Control Measures." *J. Inf. Dis.* 76, p. 216 (1945).
6. Loosli, C.G.: "Control of Cross-Infections in Infants' Wards by Use of Triethylene Glycol Vapor." *Am. J. Public Health* 37, p. 1385 (1947).
7. Robertson, O.H.: "The Lethal Effect of Triethylene Glycol Vapor on Dried Airborne Bacteria." *Am. J. Hyg.* 53, p. 69 (1951).
8. Thomas, J.C.: "Reduction of Dust-Borne Bacteria by Oiling Floors." *Lancet* 1, p. 433 (1941).
9. Thomas, J.C.: "Reduction of Dust-Borne Bacteria in Air of Hospital Wards by Liquid Paraffin Treatment of Bedclothes." *Brit. Med. J.* 1, p. 953 (1941).
10. Commission on Air-Borne Infections: "A Study of the Effect of Oiled Floors and Bedding on the Incidence of Respiratory Diseases in New Recruits." *Am. J. Hyg.* 43, p. 120 (1946).
11. Loosli, C.G.: "Recent Studies on the Control of Dust Borne Bacteria by Treatment of Floors and Bedclothes with Oil." *Am. J. Med. Sc.* 209, p. 166 (1945).
12. Lemon, H.M.: "The Suppression of Dust-Borne Bacteria by Oiling Floors and Bedclothes." *J. Inf. Dis.* 90, p. 141 (1952).
13. Rountree, P.M.: "The Treatment of Hospital Blankets with Oil Emulsions and the Bactericide Action of 'Fixanol C'." *Med. J. Australia* 1, p. 427 (1947).
14. Cade, A.R.: *Soap and Sanitary Chemicals* 23 pp. 137-141 (April 1947).
15. A.P.H.A.: *Am. J. Public Health* 34, pp. 255-258 (1944).
16. Stuart, L.S.: "Use Dilution Confirmation Tests for Results Obtained by Phenol Coefficient Method." *J. Assoc. Official Ag. Chem.* 36, p. 466 (1953).
17. Seidmann, J. and Eisenhoff, H.: "'Rooming-in' Service in Medium-Sized Community Hospital; Report on 4½ Years Observations." *New York J. Med.* 56, pp. 2533-2536 (Aug. 15, 1956).
18. McBryde, A., and Davison, W.C.: "Rooming-In." *North Carolina Med. J.* 16, p. 159-164 (May 1955).
19. McBryde, A., "Compulsory 'Rooming-In' in Ward and Private Newborn Service at Duke Hospital" *J.A.M.A.* 145, pp. 625-628, (March 3, 1951).
20. Finemann, N.: "Non Ionics, the All-Surface Cleaner." *Soap & Chem. Specialties,* (Feb.-March 1953).
21. Gadberry, H.M.: "Detergent Materials." *Industrial Detergency,* pp. 18-19, Reinhold (1955).
22. Klarmann, E.G.: "Suggested Specifications for the Buyer of Institutional Disinfectants." *Modern Sanitation* 6, pp. 15-18, (December 1954).
23. Finch, W.E.: *Disinfectants, Their Values and Uses.* London: Chapman and Hall, 1958, p. 162.
24. Sykes, G., *Disinfections and Sterilization,* London: Spon., 1958, p. 335.

Our Beauty Bar Is A Money-Maker

By Ruth V. Requa*

Our auxiliary's "beauty bar," opened in Nassau Hospital in February, 1958, is a triple-threat asset. It builds the morale of women patients, helps to attract hard-to-get nurses, and actually produces revenue. And – another point in its favor – it can be easily installed in almost any unused room of the building.

Our salon, decorated in shell pink, gray and white, is located on the first floor of the hospital, not far from the main entrance. It occupies an area of 516 square feet, has six stationary dryers, two movable ones (for use in patient rooms), two manicure tables, and one portable utility wagon.

Our four experienced, licensed operators are trained to recognize and conform to hospital routine. The shop is open six days a week, from 9 to 5:30. Twelve volunteers work as cashiers, receptionists and aides to the operators on the nursing floors. They alternate days and hours, with two volunteers a day, in morning and afternoon shifts.

Mrs. Frances Wargo, the shop's manager, recognized a need for such a facility while herself a patient in our hospital. For those confined to their beds, the shop is heaven-sent. This service is planned for the sick. The equipment is adjustable to any position, and therefore orthopedic, surgical, cardiac and maternity patients can be treated with safety. Employees load equipment on mobile carts and go through the rooms giving shampoos, sets, haircuts, and even permanents.

The shop is particularly popular with maternity patients. (We have 60 maternity beds out of a total of 315.) And "beauty bar" gift certificates are a popular item with patients' visiting relatives and friends.

Male patients use the service too, getting scalp treatments, shampoos and manicures.

The manner in which the shop operates may be unique – though the idea of having a beauty shop is not. Beauty shops in hospitals are usually operated by concessionnaires. Here, we got the shop started on our own, with an investment of $5,000 for equipment installed in what used to be a storage room. In the time since the beauty bar opened, half of that investment has already been paid off out of net income. The profit runs about 10 percent per year. We expect to do a gross of $20,000 this year, with a profit of $2,000.

In a typical week, gross income runs to about $485; daily, it is about $80. There is a daily average of 25 customers, served by 2.1 operators. Out of every 150 customers, 50 are patients, 30 are members of the auxiliary, 30 are employees and 40 are from other groups. Employees get a 10 percent discount on rates. Starting at 3 p.m., when the day shift of nurses goes off, most of the customers being treated are likely to be members of our nursing staff or our auxiliary.

With the exception of Mrs. Wargo, who is a full-time employee of the hospital, the operators are all brought in on a part-time basis as needed. But all their salaries, which are comparable to those paid in beauty shops outside, are paid by the hospital. So far, there have been no complaints from outside shops about unfair competition.

The advantages in terms of patient morale can easily be noticed by visitors to our hospital. The availability of the variety of beauty services to short-term surgical cases prior to their return home, for example, is enthusiastically appreciated, since a considerable time may elapse during a patient's convalescence at home before she can visit her regular beauty salon.

It wasn't difficult to get women patients to accept the idea of a beauty bar in the hospital. To the female sex, beauty care is as necessary as breathing. Sometimes more than pills and prescriptions are needed to bring a rosy glow to a patient's cheek.

*Past president, Women's auxiliary, Nassau Hospital, Mineola, N. Y. and an auxiliary conference member of the New York State Hospital Association.

Hospital patients get the beauty treatment. Result: a morale boost as well as a rosy glow to patients' cheeks.

SCANNING

(*Continued from page* 9)

has become the most used drug the world over, for relief of congestive pain and the symptoms of fever. Dr. Leake adds that its remarkable safety has contributed to this success, in spite of its tendency to cause allergic reactions in about five percent of cases.

Pony Tails Intact in New Surgery Technic

Women who undergo brain surgery no longer have to leave the hospital with shaved heads, according to a neurosurgeon who uses a pony tail-hair spray technic.

Jonathan M. Williams, M.D., of Washington, D.C., has his patients wash their hair with a detergent-hexachlorophene shampoo several times during three or four days prior to surgery.

Just before surgery, the hair is parted along the lines of the incision and combed into small pony tails. The nonlacquer hair spray then applied kills germs because of its high alcohol content.

Cardiacs "Send" ECG Via Short Wave

Combining short wave radio signals with the electrocardiograph makes it possible to analyze the heart by remote control as the patient works or plays under normal circumstances.

John S. Ladue, of the Sloan-Kettering Institute, New York, estimates that the new apparatus will result in electrocardiograms at least 20 percent more accurate than the present system where the patient lies still while the reading is being taken.

Present ECG machines do not permit readings on the patient while he exercises because the rhythmic up-and-down lines on the graph papers would become blurred by tremors, caused by muscle activity or "noise" in the arm or leg.

Dr. Ladue reports that he and his associates searched for some part of the body that did not have muscle activity. They tried the tip of the nose, the forehead, the toes, the cheeks. The lobes of the ears finally proved satisfactory.

A 57-year-old man who had suffered angina pains for years without apparent heart damage was put on the ECG machine while he exercised. The graph revealed an abnormality of the heart 110 seconds before the appearance of pain.

An advantage of the method is that the exercise can be stopped before the patient has symptoms, Dr. Ladue stated. With further refinements, it will be possible to record ECG results while the patient is being subjected to the stress of his normal environment.

Snails Shell Out In Tooth Study

The calcium content in his shell has made the common snail a valuable personality in the study of tooth decay. Dr. George Paffenbarger, Washington, D.C., reports that the little water animals are being studied by the National Bureau of Standards and The National Institute of Dental Research, to determine how dental enamel is formed and how it decays. The snails are exposed to radioactive compounds and the amount of uptake is measured with a geiger counter.

According to Dr. Paffenbarger, the current study is aimed at learning how calcium carbonate is incorporated into teeth as they develop in the jaws.

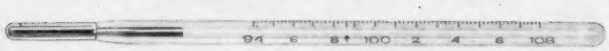
Pep Pills May Slow Down Sociability

Pep pills may endanger friendships as well as strengthen them, report Gene M. Smith, Ph.D., and Henry K. Beecher, M.D., of the Harvard Medical School.

Increased feelings of boldness and friendliness are among the effects of amphetamine. The stimulant is widely used by athletes and businessmen, but is also used by criminals who bolster their courage with the drug.

Whether the effects of amphetamine are good or bad, with regard to social behavior is questionable and depends in part upon social and environmental circumstances, state the Harvard physicians.

NEW...FROM 'HYPO'



CLINICAL THERMOMETERS

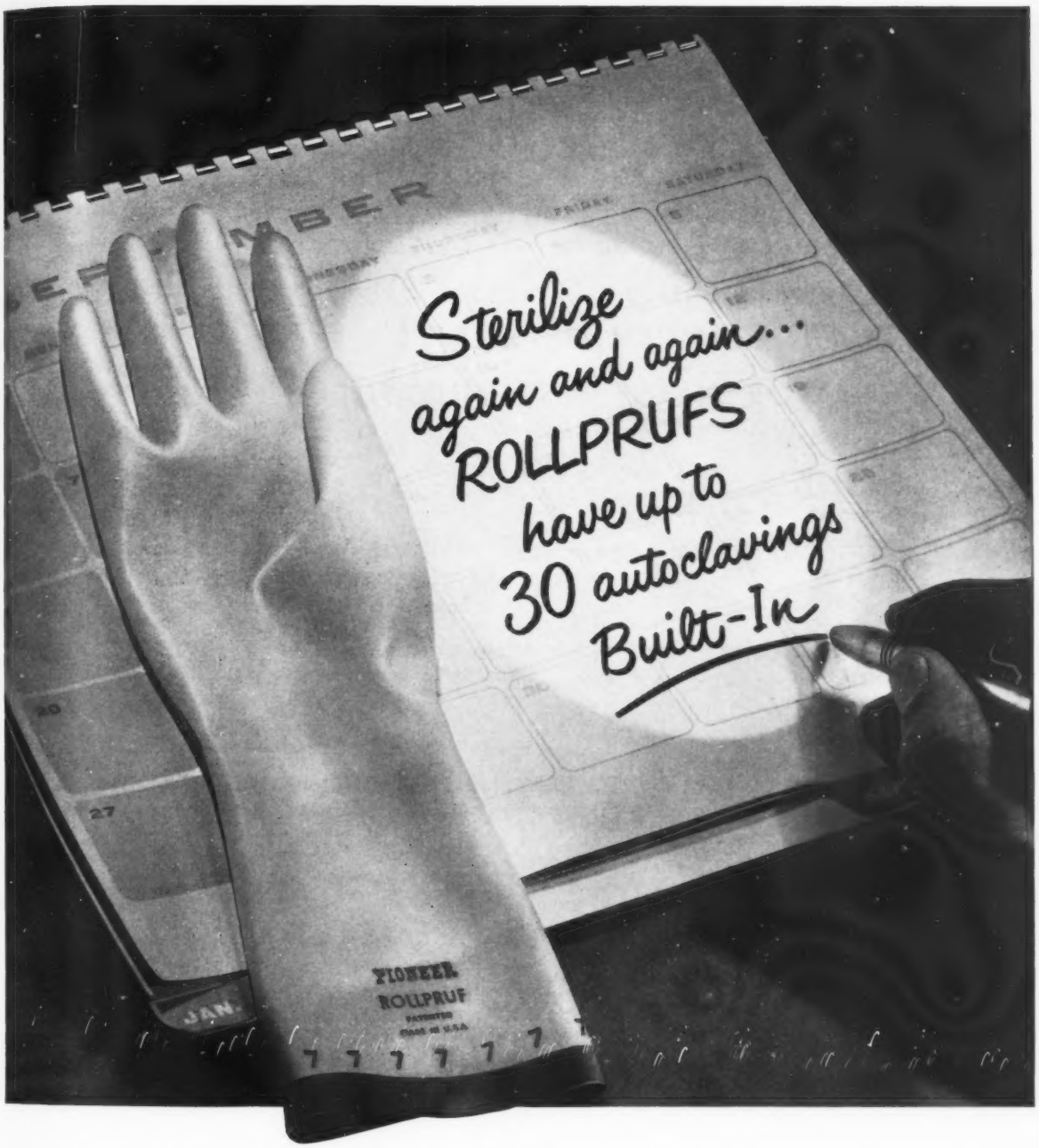
ORAL · RECTAL · STUBBY

FINEST QUALITY...LOWEST PRICE!

• PERMANENT SILICON PIGMENT • "EASY-READ" MARKINGS—RED ABOVE NORMAL
• FULLY GUARANTEED FOR DURABILITY AND ACCURACY
• COMPLIES WITH CS1-52 STANDARDS
• MEETS ALL FEDERAL AND COMMERCIAL SPECIFICATIONS

Packaged Individually, 6 Dozen To Container.
Special Hospital Pack Available, 1 Dozen Per Plastic Box.

HYPO SURGICAL SUPPLY CORP.
11 Mercer Street • New York 13, N. Y.



This is Real Economy...

Pioneer makes Rollprufs of higher tensile strength latex to minimize cuts, snags and tears . . . controls uniformity of film thickness to eliminate weak spots . . . applies the extra band at the cuff to double the reinforcement against tearing . . . offers you a free glove-handling analysis to insure the most efficient operation of your present equipment.

Free Glove Handling Analysis

Requested by_____

Title_____

_____ Hospital

City_____ State_____

The **PIONEER** Rubber Company • 328 Tiffin Road, Willard, Ohio

For further information see postcard opposite page 116.

SAVE HUNDREDS OF DOLLARS PER YEAR IN COSTLY INSTRUMENT REPLACEMENT!

NOW... you can Autoclave ANYTHING including instruments of CARBON STEEL *WITHOUT DANGER OF RUST!!!*

LORVIC
VAPOR PHASE
RUST INHIBITOR
PATENT PENDING
PREVENTS OXIDATION OF SURGICAL INSTRUMENTS IN AUTOCLAVES AND OTHER WET STERILIZERS BY . . .
ATMOSPHERIC CHANGE!
Carbon Steel Instruments such as
and scalpel blades may now be
autoclaved without danger of rusting
THE LORVIC CORP.
ST. LOUIS 12, MISSOURI

LORVIC VAPOR PHASE RUST INHIBITOR

Prevents oxidation by ATMOSPHERIC CHANGE! NOT an emulsion or a silicone . . . NOT sprayed on instruments. SIMPLE, SAFE, EASY TO USE. For packages of instruments, spray on wrapper. For unwrapped instruments, spray a cloth or towel and autoclave with instruments.

$7.50 per 10 oz. bottle

$7.00 per bottle in cases of 6

AVAILABLE SOON IN SIX OUNCE BOTTLES

LORVIC
RINSE
PREVENTS RUSTING DURING RINSE CYCLE and in HOT WATER STERILIZERS
• SPEEDS DRYING TIME...
• REDUCES SPOTTING...
• EFFICIENT IN HARD OR SOFT WATER...
THE LORVIC CORPORATION

TO PREVENT RUST DURING WASH AND RINSE CYCLES—and in HOT WATER STERILIZERS . . . USE . . .

LORVIC *RINSE*

Prevents Rust . . . Reduces Spotting . . . Speeds Drying Time . . . Dissolves Quickly . . . Efficient in both Hard and Soft Water . . . Economical.

$3.50 per 18 ounce can **$3.25 per can in cases of six**

LORVIC DECALCIFIER

FOR FAST, EFFICIENT CLEANING OF STERILIZERS, AUTOCLAVES & VAPORIZERS! Just add ½ to 1 vial Decalcifier to one pint of hot water. Soak equipment 15 or 20 minutes and flush. No dangerous acid fumes.. Easy to measure dosage.. Harmless to equipment. No rubbing or wiping.

Box of 6 32-gram Vials — $4.50

GERMICIDAL CONCENTRATE

Containing benzalkonium chloride. For cold sterilization of surgical instruments. KING SIZE ACTION at a PINT SIZE PRICE. Each 8 oz. Bottle makes 24 Quarts. Easy to measure. Anti-Rust Tablets included. Accepted by the AMERICAN DENTAL ASS'N.

8 ounce Bottle — $7.00

ORDER FROM YOUR DEALER—NOW!

The LORVIC CORPORATION
5553 EASTON AVENUE • ST. LOUIS 12, MO., U. S. A.

Canadian Distributor:
PROFESSIONAL SALES CORP. • MONTREAL 26, P. Q.

Senator Metcalf's analysis of developments in his own state and others offers valuable clues to trends of concern to everyone working in the broad areas of health and medical care.

Health Insurance Newsletter

By State Sen. George R. Metcalf*

Rate Increase Turned Down. On August 4, New York state insurance superintendent Thomas W. Thacher announced he was turning down the Blue Cross (Associated Hospital Service) request for a 37.4 percent premium rate increase. He added, however, that he would approve a "substantial" although smaller increase if a new formula for reimbursing hospitals were devised to meet his objections. He suggested the new application be submitted promptly enough for him to authorize the increase by Nov. 1.

Mr. Thacher's objections, spelled out in a 58-page statement accompanying the decision, related to apparent conflict over the matter of reimbursing the hospitals on the basis of the cost of care for Blue Cross subscribers. J. Douglas Colman, president of Associated Hospital Service, announced a new request would be formulated as soon as possible.

* * *

Blue Cross, Two to One. Since the Federal Employees' health insurance program went into effect early in July, preliminary, unofficial reports have indicated that federal workers are enrolling in large numbers in one or another of the various alternative plans now available to them. The initial indication is that all but 18 percent of federal employees will elect to take one of the types of coverage offered.

Of the 18 percent who refuse, 10 percent have indicated they are doing so because their husbands or wives, also government employees, are enrolling. This figure on the number of federal government workers married to each other was higher than had been anticipated. Some four percent of the 18 percent declining the coverage indicated they were already covered by other plans. With only four percent refusing to join up without citing a reason, it appears that 96 percent of those working for the federal government will have some form of health-insurance protection of substantial, comprehensive dimensions.

Of additional interest is the report that employees are choosing Blue Cross-Blue Shield health insurance in a two-to-one ratio over those who are electing the health insurance offered by the commercial carriers participating in the plan.

* * *

Unionists' Insurance Aided. A plan to pool the economic and political influence of labor-management welfare funds covering 3,500,000 New York union members and their families will begin to take shape in November, 1960. Initial aim of a new group to be established will be to supply a mechanism through which the trustees of the funds, which spend more than $100,000 a year on health benefits, can exchange information for mutual aid and service.

Saul Brodsky, president of the Hudson Painting and Decorating Co., who proposed that such an agency be set up, said that individual welfare funds lacked the economic, social and political power to alter community conditions in ways that would improve health protection for their beneficiaries, whereas a council could engage professional staff to collect needed data and make recommendations for better service.

* * *

Dissent on Government-Aided Medical Care. Gerald S. Parker, secretary, Accident and Health, the Guardian Life Insurance Co. of America, challenges the findings reported here in July concerning the report on "Attitudes Toward Governmental Participation in Medical Care," by Prof. Wilbur J. Cohen and assistant professors Charles N. Poskanzer and Harry Sharp, of the faculty of the University of Michigan. The report found that a majority of adults in Greater Detroit and in the U.S. as a whole favor governmental assistance in the provision of low-cost medical care.

Commenting on the methodology used, Mr. Parker writes:

"The question (used in the survey) was 'Now I would like to talk to you about things that our government might do. Of course different things are important to different people, so we don't expect everyone to have an opinion about all of these. First: the government ought to help people get doctors and hospital care at low cost. Do you have an opinion on this or not?'

"Now we think we must realize that a question asked in that way will be interpreted by most people as an offer of free help. No one seems to think of the cost of government until it is suddenly placed on his tax bill. Suppose the question had been phrased as follows: 'Do you feel that the government ought to help the people get doctors and hospital care at low prices by sharing part of the true cost and increasing taxes enough to cover its share?'

"Don't you think the answers might have been a bit different?"

(*Continued on next page*)

*Chairman, State of New York joint legislative committee on health insurance plans.

ALL NEW!

WASHER

ROTARY machines

FOR FAST LOW-COST SURGICAL GLOVE PROCESSING

DRYER

POWDERER

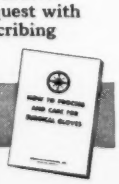
The fastest, easiest and *most economical way* to process surgical gloves is the Rotary way. For example: Even in a 100-bed hospital, these three companion machines will pay back their cost in actual savings over the hand method in less than a year.

WASHER Developed expressly for surgical gloves. Three times faster than hand method. No punishing agitators or fast rotating drums. Unique pulsating action cleans gloves thoroughly inside and out. Water drained automatically at end of each cycle. Takes only 8 minutes of operator's time. Capacity 150 gloves.

DRYER Faster, safer, because warm air at safe temperature is blown directly and continuously into tumbling drum . . . revitalizing the gloves as they dry. Excess water is removed at start of drying cycle. Drying time 30 minutes . . . three times faster than by hand. Capacity 150 gloves.

POWDERER Ten times faster than hand method. Even coating of powder, inside and out, without turning. Airtight. No powder escapes. Powdering time 4 to 8 minutes (depending on thickness of coating). Capacity 150 gloves.

FREE! GLOVE PROCESSING MANUAL mailed on request with illustrated literature describing the all-new Rotary line.



ROTARY HOSPITAL EQUIPMENT CORP.

1742 Dale Rd. Buffalo 25, N. Y.

Labor Department Findings. Much detailed information concerning the extent of health-insurance coverage among workers is given in a report entitled "Health Benefit Coverage of the Labor Force in New York State," published in February by the Department of Labor. Among highlights from the findings are the following:

- More than half the entire labor force are in job-connected programs for which the employer pays all or part of the cost.
- Nineteen percent of the labor force of New York State are without any health-insurance coverage at all.
- More than half the unemployed, the farm and domestic workers, and those in firms with only one employee, have no hospital-expense protection.
- In the field of surgical and, even more, of medical benefits, the number who have no protection runs higher than it does in the field of hospital benefits.

As the New York *Times* pointed out in a recent editorial, "Even more disturbing are the figures for the other kinds of health insurance. Some 87 percent of the labor force are without protection against catastrophic disabilities, where the economic impact is less frequent, but far more devastating financially – the 'major medical' situation. Almost one-half of those in the labor force are without coverage of the regular cost of medical care and more than a quarter have no help in meeting surgical expenses. All in all, the report is a useful revelation of what needs to be done, as well as a measure of accomplishment."

* * *

Budgeting for Health. A three-step formula for planning family medical expenditures is recommended by the Health Insurance Institute. The three steps are:

1. Figure the family's spendable income (gross income minus all deductions) and budget about six percent of this amount for health services. Health-care expenditures comprise roughly six percent of the average family's total outlay for personal needs.

2. Earmark part of the item to pay the foreseeable medical bills as they arise, such as regular health checkups, routine dental and eye care, and inoculations.

3. Allocate part of the money for health-insurance coverage against the unforeseen expenditures and the possibility of big bills.

The institute suggests that health-insurance premium money is not economically spent if it is used to purchase protection against $5 and $10 medical bills. Other authorities, however, disagree, contending that for the vast majority of low-income families, it is the repeated $5 and $10 medical bills which have the most damaging effects on otherwise comparatively well-organized budgets.

For example, George Bugbee, president, Health Information Foundation, points out that:

"The value of insurance coverage for home and office calls is often questioned, since such visits often occur regularly and are relatively inexpensive. Yet the *sum of multiple visits* can add up to a large amount for a few people and is likely to be accompanied by increased costs for hospital care, drugs, diagnostic tests, and other components of medical care."

Review of Hospital Lawsuits

By Leo T. Parker, Attorney at Law

• WORKMEN'S COMPENSATION

An important decision favoring allowance of compensation under the State Workmen's Compensation Act to employees injured in hospitals was rendered recently in the case of Sparks Memorial Hospital v. Walton, 320 S. W. (2d) 102.

Mrs. Walton was employed as housekeeper at the Sparks Memorial Hospital. One day she strained her lower back while lifting a bed. She became disabled five days later, and her incapacity still existed two years later. The state commission held that she had sustained a compensable injury, that she was temporarily totally disabled for two years, and that she had not reached the end of her healing period. It awarded Mrs. Walton compensation under the State Workmen's Compensation Act.

An appeal was filed asking that the commission's decision be reversed because the many physicians who had examined Mrs. Walton had not been able to arrive at a positive medical explanation for her condition. Despite an extensive exploratory operation and a succession of examinations and treatments, the doctors had not discovered an objective cause for the severe pain that Mrs. Walton suffered in her side, abdomen, back, and right leg.

The higher court, in approving the commission's decision, said:

"The physicians' uncertainty does not, in our opinion, compel the conclusion that the claim must be denied. There is no reason for saying that the commission, upon concluding that a compensable disability had existed for more than 18 months, should nevertheless have withheld an award pending an exact determination of the medical cause for the claimant's condition."

Joint Liability Is Lawful

"If a patient suffers an injury while in our hospital, and the evidence proves that his injury was caused by joint negligence of one of our hospital surgeons and the patient's own private physician, can the hospital be held solely liable for payment of all allowable damages to the patient?" a hospital official asks.

A leading higher court has held that if a patient suffers an injury as a result of negligence of both a physician in private practice and a hospital employee, both are jointly liable in damages to the injured patient. In other words, the courts hold that all parties, including a hospital corporation, are jointly responsible if "reasonable" care is not used to protect and safeguard a patient.

In Barra v. Spangard, 154 Pac. (2nd) 687, the testimony showed that a man consulted his family physician, who diagnosed his ailment as appendicitis and made arrangements for an appendectomy to be performed by a surgeon at a hospital. Soon afterward this man entered the hospital and was given a hypodermic injection by the surgeon. Later he was awakened and wheeled into the operating room.

After the operation he discovered that he was unable to rotate or lift his left arm. He developed paralysis and atrophy of the muscles around the shoulder. He sued the physician, the surgeon, and the hospital for heavy damages. The court ruled:

"We hold that where a plaintiff (patient) receives unusual injuries in the course of medical treatment, all those defendants who had any control over his body or the instrumentalities which might have caused the injuries may properly be called upon to meet the inference of negligence by giving an explanation of their conduct."

For further comparison, see Lamar and Smith v. Harmon, 200 S. W. (2d) 845. An ambulance driven at a high speed collided with a bus, causing serious injuries to a patient in the ambulance. The patient sued both ambulance operator and bus company.

Since the testimony showed that at the time of the accident the ambulance was being driven faster than an ordinarily prudent person would have driven it, and also that the bus operator did not give the ambulance the right of way, the higher court held that the bus company and ambulance owner must each pay one-half of the total damages awarded the injured patient. This court said:

"The weight of authority supports the general proposition, that, where the negligence of two or more persons concurs in producing a single injury, then such persons are jointly liable."

Control Fixes Liability

Another hospital official asks: "Can you outline either peculiar or usual circumstances under which a hospital operated for profit is not liable nor responsible for injuries caused by negligence of an employee of the hospital?"

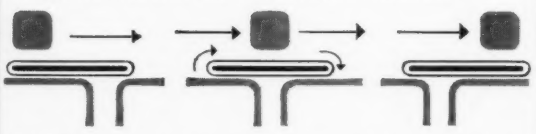
Modern higher courts consistently hold that an employer is not liable in damages for injuries caused by a negligent employee who was under

(*Continued on next page*)

MOVE Patients
FASTER SAFER
with Davis Patient Roller

Now! Move patients with minimum strain with the Davis Patient Roller! A Gilbert Hyde Chick product, the Roller is a must in hospital rooms and X-ray. Even the heaviest patient can be moved safely, quickly, effortlessly. Lightweight. Superb aluminum and steel construction. Write today for more information.

Patient moves as the Roller moves



BUT patient moves farther than Roller

GILBERT HYDE **CHICK** COMPANY
MAIN OFFICE AND PLANT • 821 - 75th AVE. • OAKLAND 21, CALIF.
GENERAL SALES OFFICE • 5 BROADWAY • EAST PATERSON, N. J.
Mfrs. and Distributors of Hospital Orthopaedic and Fracture Equipment

NO BETTER THAN THE BEST
but
HANDIER THAN THE REST

Steri-Spools®

Superior Surgical Wire on *stainless steel* spools that fit the Handy Halliday Wire Dispenser. *Ready to autoclave.* B&S guage 18 to 40.

NO SNARLS — NO KINKS — NO WASTE

If your dealer cannot supply, write to the manufacturer—

THOMAS W. HALLIDAY
919 N. WESTMOUNT DRIVE **LOS ANGELES 46, CALIF.**

FIRST CHOICE of NURSES

COOL COMFORT *plus choice of colors and fabrics*

for Operating and Delivery Room, Lab and Nursery

"MARVELLA"
Nurse's Surgery Cap
with DRAW STRING or ELASTIC BACK

Pat. No. 2,666,925

Write for Illustrated Catalog

HOLLYWOOD TURBAN PRODUCTS CO.
1104 S. Wabash Ave. **Chicago 5, Ill.**

control of another party at the time of the injury.

In McCowen v. Most Precious Hospital, 253 Pac. (2d) 830, the testimony revealed that a woman named McCowen was admitted to a hospital for surgery to be performed by her personal physician, Dr. Puckett. She was prepared and taken to the operating room by nurses and attendants employed by the hospital. She was placed upon an operating table and given a spinal block by her physician.

Later he left the nurses in charge of the patient, after directing them what to do, and went into an adjoining room in preparation for the operation. During his absence, the nurses permitted Mrs. McCowen to fall, and she suffered severe injuries.

The patient sued for heavy damages. The higher court decided that when a nurse employed and paid by the hospital is under the operating surgeon's special supervision and control, the surgeon is solely liable for injuries to the patient caused by the nurse's negligence. The court said:

> **"The rule deduced is that where a hospital nurse, although not in the regular employ of the operating surgeon, is under his special supervision and control during the operation, the relationship of master and servant exists and the surgeon is liable."**

If a nurse is under the control, direction or orders of a private physician or surgeon at the time she negligently causes injuries to a patient, the court said, the hospital automatically is relieved from liability, although the nurse is a hospital employee.

Attractive Nuisance Law

Few hospital officials and employees realize that the term "attractive nuisance" means something that will attract children and cause their injury. The higher courts hold hospital corporations are liable in damages for injuries to children resulting from "attractive nuisances." This rule of law is applicable to all things that naturally attract children.

For example, in Johnson v. Wood, 21 So. (2d) 353, it was shown that a corporation had on its premises near the street, a mortar box containing a mixture of lime, sand, and other ingredients. The box was unguarded and unprotected.

One day a boy threw some of the contents of the mortar box into the face and eyes of another child, who lost the sight of one eye. The injured child's parents sued the corporation for damages.

Although the lower court held the corporation not liable, the higher court reversed the verdict, saying:

"It is a well-known fact that a mortar box will lure children of tender years while it would repel those of more mature years . . . In a case like this, it is no answer to say that appellant (child) had no business there or that her parents should have forbidden her going on the premises."

The motto which may be drawn from this decision is: While a danger may be apparent to an adult, it is not so to children. Therefore, no dangerous thing "attractive" to children should be left in a location likely to be found by children.

8 second magic in I.V. set-ups with the Cutter Saftisystem "28" ™†

remove metal seal and disc

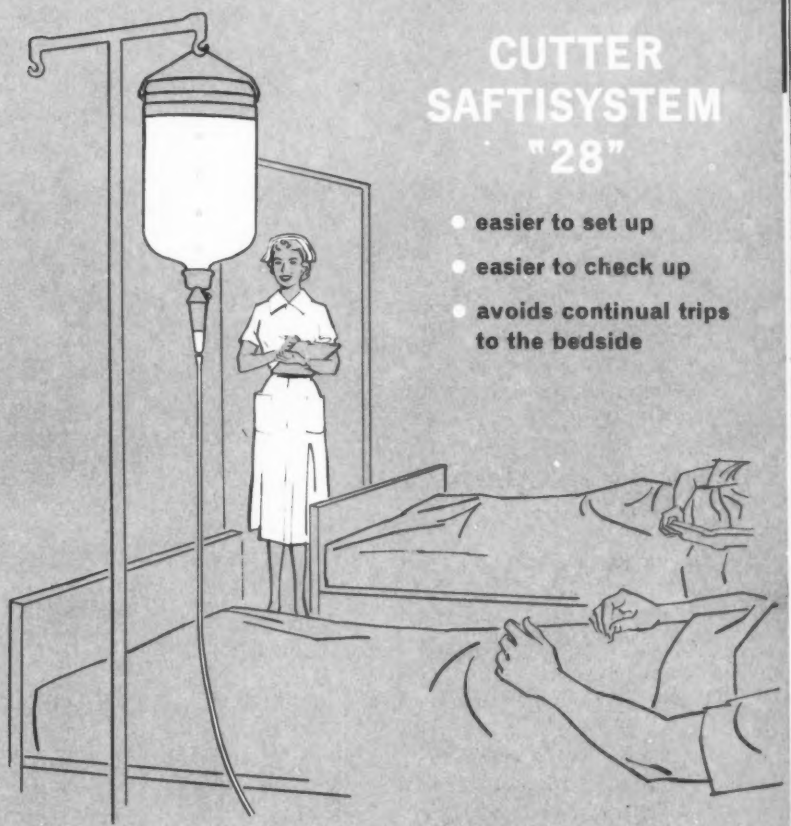
plug set into center of stopper with a quick thrust

quickly invert bottle to visually check for vacuum and to automatically establish fluid level in drip chamber; clear tubing of air and infuse

†Patent Pending

SINCE CUTTER 1897

LONG DISTANCE CHECKING FOR NEEDLE STOPPAGE BECOMES POSSIBLE WITH THE

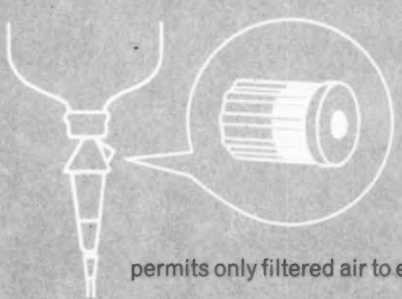


CUTTER SAFTISYSTEM "28"

- easier to set up
- easier to check up
- avoids continual trips to the bedside

With old type bottles with an air tube, nurses have to walk to the bedside to determine the flow of an infusion by observing fluid dripping in the chamber. But with the Saftisystem "28," nurses looking into a patient's room from as far away as the hallway can see if the solution is flowing by noting the rising air bubbles. Thus nurses save steps, save time and have an accurate means of checking the flow of an infusion from a distance.

ONLY FILTERED AIR ENTERS THE SAFTISYSTEM "28"



A fine mesh, non-wettable, bacteriai filter permits only filtered air to enter the Saftisystem "28"

THE FIRST MAJOR ADVANCE IN SOLUTION SYSTEMS SINCE DISPOSABLE SETS

The Cutter Saftisystem "28" consists of a 28 mm. Saftiflask® and improved injection sets. A new air inlet with a filter does away with the air tube, permits use of a solid stopper with a single point of entry, and permits only filtered air to enter the flask.

The Saftisystem takes just 8 seconds to set up. There's no searching for the point of entry as there's only one place in the stopper where the set plugs in. The bottle, when inverted, automatically establishes a level in the drip chamber, and the incoming filtered air bubbling up gives a visual check for vacuum.

Medication can be added (aseptically) either before or after the flask has been suspended on the T stand, even after infusion is started.

Hospitals can convert to the Saftisystem "28" without confusion as it is compatible with all closed systems of I.V. administration.

SEND FOR COMPLIMENTARY WALL CHART EXPLAINING THE SAFTISYSTEM "28" IN DETAIL.

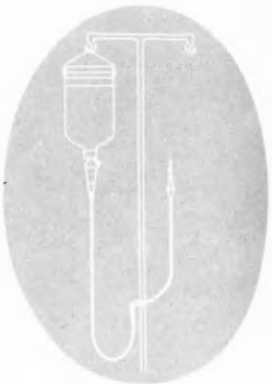
CUTTER LABORATORIES
Berkeley, California

COMMON SOLUTION SET-UPS WITH THE SAFTISYSTEM "28"

I. V. SET-UP

SAFTISET "28"™

The rubber stopper is exposed and the set plugged in with one thrust. Then bottle is inverted to automatically establish a fluid level in drip chamber. Tubing is cleared of air. Takes about 8 seconds.



I. V. TANDEM SET-UP

SAFTISET-TANDEM "28"™

Tandem setups become easy as bottles hook up through the air inlets and the flow automatically transfers from one flask to another as the containers empty.

I. V. "Y" Set-Up for Two Solutions

SAFTISET-Y "28"™

Hypodermoclysis Set-Up

SAFTICLYSIS "28"™

Blood Tandem Set-Up

SAFTIFILTER-TANDEM "28"™

™TM

"Y" Set-Up for Blood and Solution

SAFTIFILTER "28"™

Well-Planned Layout Improves Efficiency

By Pat Murphy*

When I learned that our new special services pavilion at Jewish Hospital would contain new quarters for our pharmacy, I took a deep breath at last. Instead of an overcrowded room of some 405 square feet, where my associates were getting in each other's way, plus a few isolated storage areas in nooks and crannies of the hospital, I would now have some 2,500 square feet in which to organize my entire operation in one area, so that work could be done easily and efficiently. We would no longer need to waste time chasing around the hospital to other storage areas.

Before construction of the new pavilion, the hospital administrators said: "Put down on paper your recommendations for the equipment you need and the arrangement you want, to make this pharmacy *work*." The results are shown on these pages.

Items used most often are placed in the position of easiest access, and we use an alphabetical arrangement of medicines according to the generic—not the brand—name. Ampules are stored in conveniently arranged drawers and our eye-ear-nose-throat items are all together in a self-contained area.

We installed a still with a faucet connection at a sink for distilled water, saving time and labor in picking up bottled water.

We installed a walk-in refrigerator, so I could purchase in bulk, certain medicines we use in quantity, giving us a price advantage. When the quantity cost on a medication is $17 per vial as compared to $21.80 for a single vial, and the hospital uses a considerable number of them, it doesn't take long to amortize the cost of the refrigeration unit.

If the opportunity arises for me to make a quantity purchase of an item for discount reasons, requiring an outlay that stretches my normal operating budget for the particular period involved, the hospital administration is usually receptive to my arguments to rearrange the month-by-month appropriations. Some institutions working under strictly established budget appropriations cannot always do the same, of course.

The pharmacy committee of the medical staff has also cooperated in supplying lists of acceptable duplicate pharmaceuticals as a buying guide. This helps us avoid duplication and waste in inventory. For example, the pharmacy formerly stocked 45 antispasmodics—now, we carry eight. Our current hospital formulary contains from 600 to 700 items.

Our pharmacy stocks some 2,556 separate items, many of which are tinctures, ointments, elixirs and capsules we compound ourselves.

We supply the needs not only of our own patients but of four other divisions of our institution as well: the May Institute for Medical Research, the Child Guidance Home, the outpatient division and the school of nursing. In addition, two neighboring separate institutions are served. Our working day, therefore, must be planned carefully, to give fastest, most efficient service to each.

From 8 to 10 a.m. we prepare the house prescription orders for

(*Continued on next page*)

Pharmacy section in new special services pavilion at Jewish Hospital is 2500 sq. ft.—a far cry from former arrangement of 405 sq. ft. plus a few isolated storage areas. Note prepackaged medicines on counter against far wall: 113 items are prepackaged, covering 95 percent of the daily inpatient medicinal requirements.

*Chief pharmacist, Jewish Hospital, Cincinnati, O.

LEFT: Owren Coffey, R.Ph., checks items in new bulk-storage, walk-in refrigerator. Since medicines used in quantity can be purchased in bulk, the resulting price advantage will soon amortize the cost of the refrigeration unit.

RIGHT: Pat Murphy, R.Ph., and author of this article, handles paperwork at his desk. With new efficient arrangement he can handle hospital's increased pharmacy requests with no increase in staff.

BELOW: Antibiotic proof sheet has been instituted both as patient service and pharmacy control sheet. Nurse records antibiotic dosage at the time given, which prevents possibility of double-billing patient due to error in making out charge slips.

THE JEWISH HOSPITAL
CINCINNATI, OHIO
PHARMACY DEPARTMENT

ANTIBIOTIC PROOF SHEET

FLOOR_____ DATE_____

DATE	PATIENT'S NAME	ROOM NUMBER	PROCAINE PENICILLIN 1 C.C.= 300,000 U	STREPTOMYCIN 1 C.C.= ½ gm.	S-R PENICILLIN 1 C.C.= 400,000 U	PENICILLIN AQUEOUS 1 C.C.= 200,000 U *		TIME	NURSE

WECKINK
STERILIZING BAG
Printing turns GREEN when autoclaved
DATE 1/15 SIZE 5 cc TYPE
Another "First" by EDWARD WECK & CO., DIVISION STERLING PRECISION CORP.
135 Johnson St., Brooklyn 1, N.Y.
BEFORE
PRINTING TURNS GREEN WHEN AUTOCLAVED*
AFTER
*WECK'S EXCLUSIVE PROCESS

Now available in many sizes

WECKINK STERILIZING BAGS

The acceptance of WECKINK STERILIZING BAGS has been so great that additional sizes for handling more items became a necessity. The present range is shown at the right.

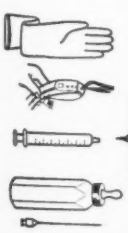
In addition to PROOF OF AUTOCLAVING†, these bags offer the following advantages:

- water-resistant glue—bag will not come apart during or after autoclaving.
- complete steam penetration—the special paper used in WECKINK BAGS allows complete steam penetration of the contents.
- wet-strength paper—resists tearing when wet.

Weck's complete line of Sterilizing Bags accommodate most *every* item for autoclaving!

If you haven't tried WECKINK STERILIZING BAGS you will discover that they are the most convenient and most economical (labor and material considered) method of packaging for autoclaving.

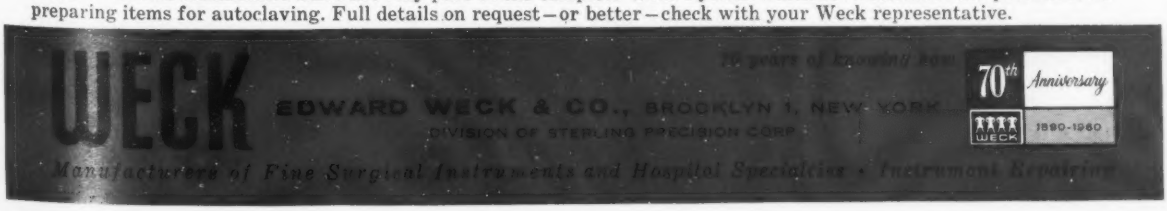
Write for free samples and prices including special contract prices.



A. SURGEON'S GLOVES, FANFOLD TOWELS, COTTON BALLS, V-PADS — 10½" x 6"
B. CATHETERS—22" x 2½"
C. SYRINGES—30 and 50 cc—10" x 2½"
D. SYRINGES—10 and 20 cc—8" x 2½"
E. SYRINGES—2 and 5 cc—6" x 2½"
F. NIPPLE CAPS—4" x 1½" x 2½"
G. NEEDLES — 4" x 1⅛" • ***(and a host of other small items)***

†Autoclaving is not, per se, proof of sterility.

NOTE: WECKINK STERILIZING BAGS are only part of the complete Weck System which revolutionizes the procedure of preparing items for autoclaving. Full details on request—or better—check with your Weck representative.


WECK
EDWARD WECK & CO., BROOKLYN 1, NEW YORK
DIVISION OF STERLING PRECISION CORP.
Manufacturers of Fine Surgical Instruments and Hospital Specialties • Instrument Repairing
70th Anniversary
1890-1960

For further information see postcard opposite page 116.

(*Continued from page* 56)

icines. Typically, because these are individual, special orders, on which a label must be typed, it may take us an hour to handle only 12 or 15 of these orders. From 2 p.m. until 4 p.m. we handle our employee requests and the orders from divisions and the adjacent institutions. We offer pharmaceutical supplies to our employees at a substantial discount, and for some families this can represent a noticeable bonus in take-home pay. Our other divisions are in adjoining buildings, so there is no major problem involved in supplying their daily needs.

In addition to our system of prepackaging for quick dispensing, we provide a printed list of standard items to both patient areas and operative areas for their convenience in ordering from us. This saves their time in writing out orders and our time in deciphering.

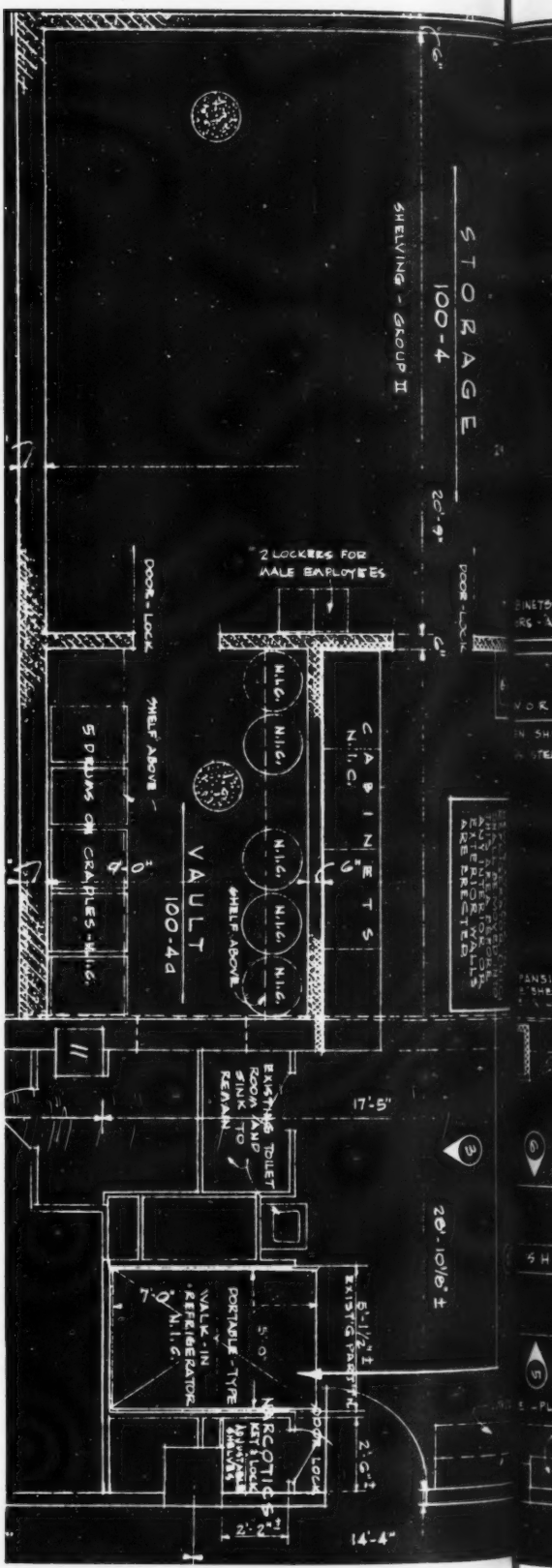
One other form we have instituted, both as a patient service and a control record for ourselves, is an antibiotic proof sheet. On this sheet, the nurse lists the dosage *at the time given*. This prevents the possibility of the patient being double-charged because of an error in making out charge slips for antibiotics. The patient is also accommodated by Jewish Hospital's policy which provides a reduction from the regular price when the patient is under very heavy dosage of an antibiotic in any 24-hour period. The antibiotic proof sheet helps to verify the billing charges for this as well.

Seeing pharmaceutical salesmen is a part of the hospital pharmacist's job, and since frequently there will be more than one competitive salesman calling at the same time, our pharmacy is designed so that the salesman's waiting room is separated from the pharmacist's main office.

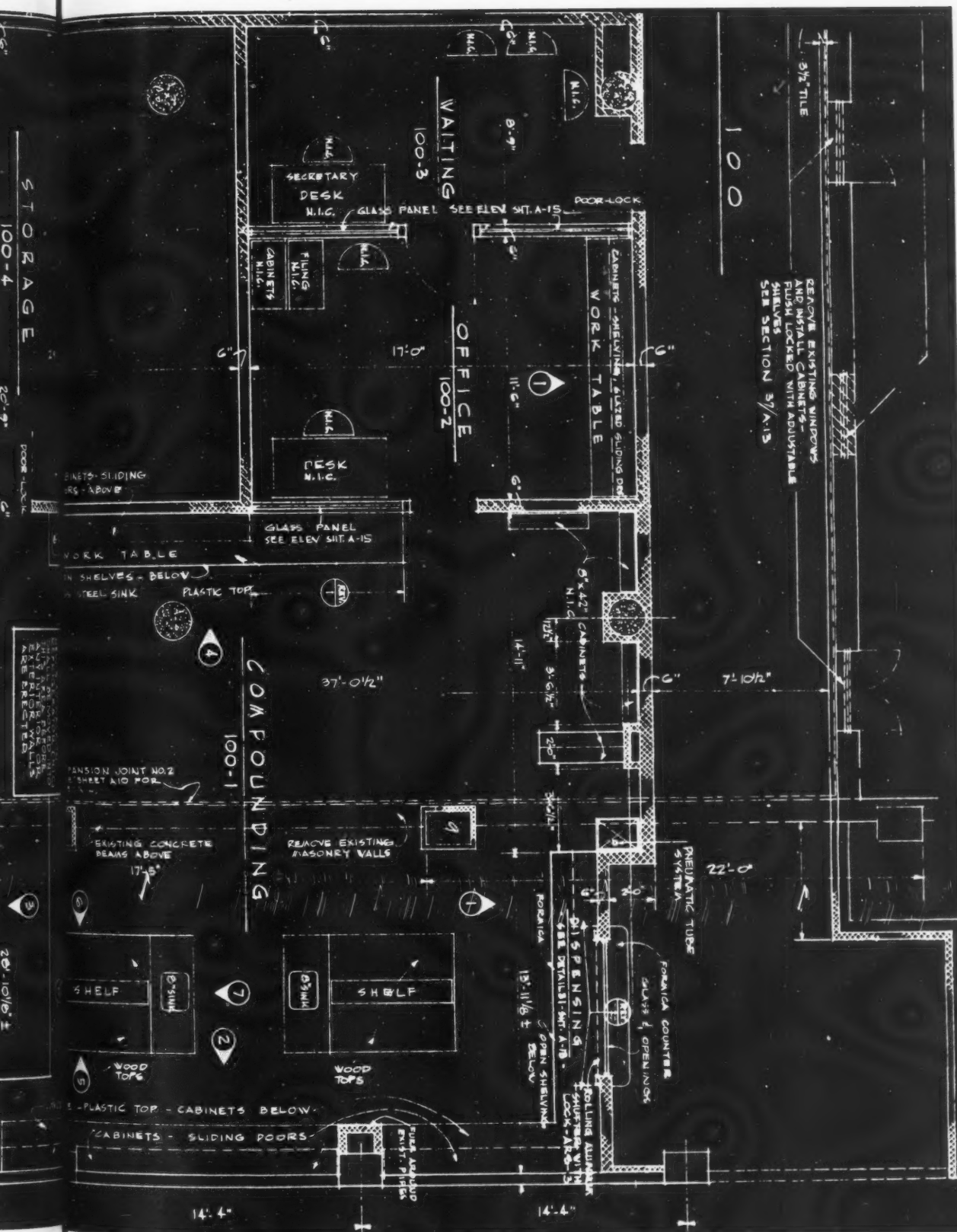
Our pharmacy employs five pharmacists, one clerk-secretary and one porter-messenger-janitor. We teach two pharmacist-interns.

The efficient and pleasing design of our new pharmacy's work area helps us give faster and better service to the patient, at greater economy.

(*See page* 60 *for antibiotic form*)



Architect's drawing of pharmacy layout at Jewish Hospital


WAITING
100-3
SECRETARY
DESK
N.I.C.
GLASS PANEL SEE ELEV SHT. A-15
POOR-LOCK
CABINETS N.I.C.
FILING N.I.C.
OFFICE
100-2
DESK
N.I.C.
WORK TABLE
CABINETS - SHELVING, GLAZED SLIDING DOORS
REMOVE EXISTING WINDOWS AND INSTALL CABINETS - FLUSH LOCKED WITH ADJUSTABLE SHELVES SEE SECTION 3/A-13
100
8½" TILE
STORAGE
100-4
GLASS PANEL SEE ELEV SHT. A-15
WORK TABLE
PLASTIC TOP
8'x42" N.I.C. CABINETS
37'-0½"
7'-10½"
COMPOUNDING
100-1
EXISTING CONCRETE BEAMS ABOVE
17'-8"
REMOVE EXISTING MASONRY WALLS
22'-0"
PNEUMATIC TUBE SYSTEM
FORMICA COUNTER SLABS & OPEN NOOK
DISPENSING
SEE DETAILS SHT. A-13
ROLLING ALUMINUM SHUTTER WITH LOCK-ARM
OPEN SHELVING
FORMICA
12'-11⅛" ± BELOW
SHELF
SINK
WOOD TOPS
PLASTIC TOP - CABINETS BELOW
CABINETS - SLIDING DOORS
FIXED ASBESTOS EXIST. PIPES
14'-4"
14'-4"

FORM 54-A-9-59 R62

THE JEWISH HOSPITAL CINCINNATI, OHIO

PHARMACY REQUISITION (Excluding Proof Sheet Items)

FOR USE OF CENTRAL SUPPLY, RECEIVING AND EMERGENCY, RECOVERY, SURGERY, 500 AND 600 FLOORS, AND X-RAY

NURSING AREA INCLUDING X-RAY_____ DATE_____

UNITS REQUESTED	UNITS	ITEM	COST*	UNITS REQUESTED	UNITS	ITEM	COST*
	1 Oz.	Adrenalin, Topical, Sol.			1 Oz.	Desitin Ointment	
	Gal.	Alcohol, Blue			Can	Desitin Powder	
	100	Alophen, Tab.			6 Ea.	Dexin, 3 Lb. Can	
	1 Oz.	Americaine Oint., Tube			12 Ea.	Dextri Maltose No. 1—1 Lb Can	
	Gal.	Aro Brom., Sol.			12 Ea.	Dextri Maltose No. 2—1 Lb. Can	
	100	ASA 5 Gr.			Case	Dryco No. 3 Can	
	1000	ASA Compound, Tab.			24 Ea.	Lactum	
	1 Lb.	Balsam of Peru			Gal.	Phisohex, Detergent	
	Pt.	Carbon Tetrachloride			Case	SMA 12 Oz. Liquid	
	100	Ergotrate Amps., 1/320 Gr.			Case	Sobee 12 Oz. Can	
	100	Ergotrate Tab., 1/320 Gr.				SURGERY ONLY	
	4 Oz.	Ether, Can			Gal.	Ceepryn 1:100 Sol.	
	Gal.	Ether			Gal.	Ceepryn 1:100 Tinc.	
	8 Oz.	Hand Lotion			10 CC.	Congo Red Amps.	
	24 Oz.	Instrument Oil			60 CC.	Cyclaine HCL, Sol. Topical	
	100	Methergine Amps. 1 CC. 0.2 Mg.			100	Dextrose Amps., 10%, 3 CC.	
	Gal.	Merthiolate Tincture			1 Oz.	Diothane Cream, Tubes	
	200 CC.	Metycaine HC1, 1.5 Amps.			1 Oz.	Diothane Ointment, Tube	
	Gal.	Mineral Oil			5 CC.	Dramamine Amps., 50 Mg/CC.	
	½ Oz.	Neosynephrine ¼% Sol.			Pt.	Geranium	
	6 CC.	Novocain 1% Amps.			5 CC.	Indigo Carmine Amp., 0.8%	
	3 CC.	Novocain 2% Amps.			Gal.	Merthiolate Sol.†	
	3 CC.	Novocain Suprarenin 1:20,000 Amps., 2%			1 Oz.	Methylene Blue 1% Sol †	
	3 CC.	Novocain Suprarenin 1:50,000 Amps., 2%			1 Lb.	Monsel's Sol.†	
	1 Oz.	Pontocaine ¼%, Sol.			1 Oz.	Negatan, Sol.—Bottle	
	1 Oz.	Pontocaine ½%, Sol.			5 CC.	Neosynephrine 1%, Vials	
	1 Oz.	Pontocaine 2%, Sol.			1 Oz.	Nupercainal Oint., Tube†	
	50 Ea.	Pontocaine 1% Amps., 2 CC.			1 Ea.	Ozium, Aerosol	
	10 Ea.	Pontocaine 0.2% With Dextrose 6%, Amps.			4 Oz.	Pitocin Amps., 1 CC., 10 Units	
	20 CC.	Seconal Amps., ¾ Gr./CC.			Qt.	Skiodan 20%, Sol.	
	20 CC.	Sodium Chloride, Sol., Isot.			1000	Sodium Chloride, Tab., 1 Gm.	
	1 Gm.	Sodium Pentothal, Powder			10 CC.	Succinyl Choline Chloride, 20 MG/CC.	
	5 Gm.	Sodium Pentothal, Powder			25	Succinyl Choline Chloride 1000 MG/Vial	
	5 Gm.	Sodium Surital, Powder			Each	Tubocurarine, Sol., 3 MG/CC., 10 CC. Vial	
	100	Synkayvite 10 Mg., Amps.			3 Lb.	Vaseline, Jar†	
	30 CC.	Water for Injection			50 CC.	Vinethene (Ether) Can	
	Gal.	Zephiran Tincture			Each	Xylocaine 1%, 50 CC. Amp.	
		CENTRAL SUPPLY ONLY			Each	Xylocaine 2%, 50 CC. Amp.	
	35 Lb.	Vaseline, Can			50 CC.	Xylocaine 1% With Epinephrine 1:100,000	
		500 FLOOR, 600 FLOOR, SURGERY ONLY: *			50 CC.	Xylocaine 2% With Epinephrine 1:50,000	
	100	Infundin Amp., 1 CC.			50 CC.	Xylocaine 2% With Epinephrine 1:100,000	
	100	Methergine Amps., 1 CC.			Gal.	Zephiran Sol., 1:1000 Anti-Rust	
	100	Pitocin Amp., 1 CC.			Gal.	Zephiran Sol., 1:5000†	
	100	Scopolamine Amp., 1 CC.				X-RAY ONLY	
	100	Vasoxyl Amp., 1 CC.			20 CC.	Cholografin Amp.	
		R & E ONLY			30 CC.	Hypaque Amp.	
	24 Oz.	Aluminum Acetate, Bottle			3	Pantopaque Amp., 3 CC.	
	Each	Coricidin Tab.			25	Telepaque Tab., 6's, 0.5 GM.	
	24 Oz.	Dakin's Solution, Bottle			20	Urokon Amp., 30%, 25 CC.	
	Each	Darvon Compound, Capsules			20	Urokon Amp., 50%, 25 CC.	
	Each	Edrisal, Tab.			20	Urokon Amp., 70%, 25 CC.	
	5 Oz.	Gelusil, Bottle				500 FLOOR ONLY	
	Each	Nembutol Suppositories, 1 Gr.			100	Dextrose Amps. 50%	
	Each	Nembutol Suppositores, 2 Gr.			6 Oz.	Kaopectate—Bottle	
	Each	Nembutol Suppositories, 3 Gr.			½ Oz.	Mammol Ointment	
	½ Oz.	Neosynephrine 1% Sol.			1000	Methergine Tab., 0.2 MG.	
	½ Oz.	Neosynephrine 0.5% Sol.			100	Synkamin, 1 MG. Amp.	
	3 CC.	Novocain 2% Amp.				600 FLOOR ONLY	
	30 CC.	Novocain 2% Vial			Gal.	Alcohol 70% With Anti-Rust	
	Can	Turgasept Deodrant			Pt.	Cardamon Compound Tr.	
		NURSERY ONLY			8 Oz.	Iodine, Tincture—Bottle	
	24 Ea.	Alacta			100	Quinine 5 Gr. Cap.	
	Can	Bakers Modified			100	Silver Nitrate Wax Amps., 1%	
	24 Ea.	Dalactum			Pt.	Skiodan 20%, Sol.	

*PHARMACY USE ONLY
†R & E ALSO

INDEX OF ABBREVIATIONS: Isot. — Isotonic; Sol. — Solution; Tr. — Tincture; El. — Elixir; F. Ext. — Fluid Extract; Ht. — Hypodermic Tablet

(Another requisition form is used for patient areas.)

prescription pad

Anesthetic Suppository

Medicone Company has recently introduced a new, anesthetic hydrocortisone suppository, Rectal Medicone-HC, for symptomatic control of severe anorectal inflammation, pruritis, and pain.

Supplied in "breakback" boxes of 12 suppositories.

Antidiarrheal Tablet

Polymagma tablets for the control of bacterial diarrhea are now available from Wyeth Laboratories. The tablets contain two antibiotics – polymyxin and dihydrostreptomycin – which provide combined bactericidal action against most enteric pathogens.

Each tablet also contains 350 mg. of claysorb which is effective in absorbing the viruses coxsackie, ECHO and poliovirus types 1, 2, 3.

Polymagma tablets are supplied in bottles of 48. For children and infants it is suggested that Polymagma Suspension be used.

Appetite Suppressant

Geigy Pharmaceuticals has announced a new nutritionally supplemented form of the appetite suppressant Preludin, under the name of Prelu-Vite. The new preparation is designed to fortify the patient's nutritional status as well as to promote the loss of excessive adipose tissue.

If taken in the recommended daily dosages, Prelu-Vite provides the "normal, adult daily requirements" for Vitamins A, C and D and the six major B-complex components.

Available in bottles of 100 capsules, each containing 25 mg. of Preludin plus vitamins and minerals.

Anti-Seborrheic Shampoo

A new therapeutic shampoo, Sebulex, is announced by Westwood Pharmaceuticals for the treatment of dandruff, oily scalp and seborrheic dermatitis.

The product contains Sebulytic, a combination of surface-active cleansers and wetting agents, and Kerohydric, a dewaxed, oil-soluble keratin-moisturizing fraction of lanolin, plus micropulverized sulfur, salicylic acid and hexachlorophene.

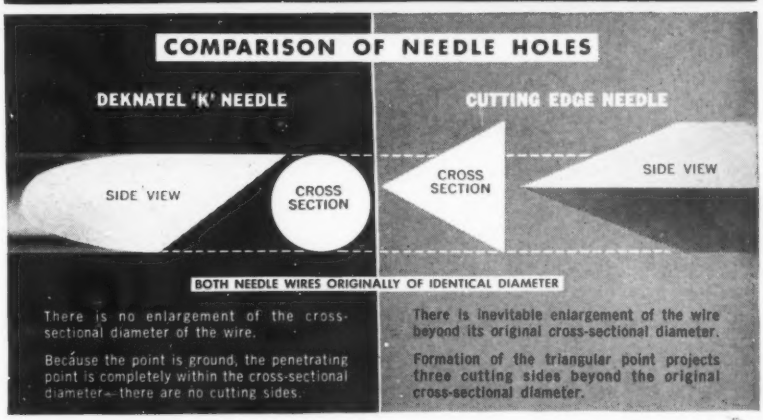
Sebulex is used in the same manner as a regular shampoo and is supplied in 4 ounce plastic bottles.

Ringworm Treatment

A new fungistatic agent for treatment of ringworm has been introduced by McNeil Laboratories, Inc. Administered orally, Grifulvin is absorbed from the gastrointestinal tract and deposited in the keratin of the skin.

Available in bottles of 20 and 100 tablets.

WHY SURGEONS SPECIFY
THE ALL-PURPOSE
DEKNATEL 'K' NEEDLE
(U. S. Patent No. 2,869,550)


COMPARISON OF NEEDLE HOLES
DEKNATEL 'K' NEEDLE
CUTTING EDGE NEEDLE
SIDE VIEW
CROSS SECTION
CROSS SECTION
SIDE VIEW
BOTH NEEDLE WIRES ORIGINALLY OF IDENTICAL DIAMETER
There is no enlargement of the cross-sectional diameter of the wire.
Because the point is ground, the penetrating point is completely within the cross-sectional diameter—there are no cutting sides.
There is inevitable enlargement of the wire beyond its original cross-sectional diameter.
Formation of the triangular point projects three cutting sides beyond the original cross-sectional diameter.

The Deknatel 'K' Needle point is a true scalpel, the sharpest penetrating instrument that can be made. The shaft of the needle easily follows this penetrating point. Cutting sides are not needed to facilitate passage of the needle—the hole is therefore that of a taper point needle. In summation, the Deknatel 'K' Needle has all the advantages of both conventional types and none of their disadvantages.

The Deknatel 'K' Needle is neither cutting nor taper needle but an all-purpose combination of both. O.R. preparation is simplified. A single Deknatel 'K' Needle may be stocked instead of the two formerly required: conventional taper and cutting. With this standardization of one for two, there are savings in inventory and storage space.

MAIL THIS COUPON FOR FREE SAMPLES AND LITERATURE

DEKNATEL, 96-67 222 Street, Queens Village 29, L. I., N. Y.

SEND FREE SAMPLES OF THE DEKNATEL 'K' NEEDLE
(Please specify type and size desired, such as "Skin, 3-0 Silk")

NAME _____ TITLE _____

HOSPITAL _____ CITY _____ STATE _____

For further information see postcard opposite page 116.

to make the most of your talents and techniques . . .

Lahey Gall Duct Forceps

The inherent dependability of a fine surgical forceps is nowhere better demonstrated than in this Lahey clamp. Note the smooth longitudinal serrations, the slender jaws and shanks, properly delicate, yet with the strength and resilience necessary for reliable clamping. 7½ inches. Stainless steel. Order as No. SU-10524, each $8.50.

VMUELLER & CO.

Fine Surgical Instruments and Hospital Equipment Since 1895

330 S. HONORE STREET, CHICAGO 12, ILLINOIS • DALLAS • HOUSTON • LOS ANGELES • ROCHESTER, MINN.

For further information see postcard opposite page 116.

THE LAB

Checks and Rechecks Halt Transfusion Errors

By E. S. Olson, M.D.*

Errors in blood transfusions need not occur. When they do happen, they can usually be traced to the carelessness of some individual, his lack of knowledge, or his failure to follow through on a particular part of the procedure.

In an effort to do away with costly errors – costly in lives, in time, in money – we have instituted a system of controls, requiring each person involved in the procedure to exercise utmost care. Each employee initials his part of the work, and his own errors are thus traceable directly to him.

Our aim is not to "trap" the personnel. Our sole concern is the safety of the patient. However, we have found that our personnel take a deeper interest in each stage of the blood-transfusion procedure if they are required to show that they have personally watched over a particular segment of it.

Each patient, at time of admission, is given an identifying wrist band, which carries his name and hospital serial number.

In emergency cases that are not admitted in the usual manner, the medical technologist attaches a wrist band, and inserts the exact time that the blood for cross-matching was taken, then initials the band. We feel this serves as an accurate identification of the patient as far as transfusions are concerned, in the absence of a hospital number. The technologist cannot take blood from two different patients at the same time.

In emergency cases, the wrist band will also include the patient's name, when obtainable, but we consider this insufficient for final identification.

The patient's hospital number, name, and room number must appear on all requests for transfusions. The hospital number is emphasized by placing it before the name and room. The latter information merely leads us to the patient with the recorded hospital number.

When blood is requested for a transfusion, the technologist must initial the certification. This certification is item IV on our transfusion form (Fig. 1). After the typing is completed, the clerk or technologist who records the results must certify that those results are being recorded in the proper clinical record, by initialing the certification (item V, Fig. 1).

This procedure involving two separate certifications insures that

(*Continued on next page*)

Fig. 1. Transfusion Form

BLOOD TYPING — TRANSFUSION — COOMBS TEST **BUSINESS OFFICE**

HOSPITAL NO.____ ROOM____ AGE____ NAME____

DOCTOR____ DATE____ CHARTED BY____

DIAGNOSIS

PATIENT PREVIOUSLY TRANSFUSED: YES NO	REQUESTED	CHARGES
I REQUEST THAT PATIENT BE TYPED ONLY____ Rh FACTOR ONLY____		
II REQUEST THAT PATIENT BE TYPED & CROSS MATCHED		
a. TRANSFUSION TO BE GIVEN AS SOON AS POSSIBLE		
b. TRANSFUSION TO BE GIVEN: DATE A.M. P.M.		
c. NUMBER OF TRANSFUSIONS DESIRED		
d. BLOOD TO BE AVAILABLE FOR POSSIBLE FUTURE USE		
III SPECIAL REQUEST		
a. CELL MASS		
b. PLASMA: LIQUID____ LYOPHILIZED____		
c. ALBUMIN, CONCENTRATED (SALT FREE) 50 cc Equiv. 250 cc		
d. FIBRINOGEN		
e. OTHERS (COOMBS TEST, ETC.)		

IV CERTIFICATION: This is to certify that the hospital number on this request corresponds with the number on the wrist band____ Tech.

PATIENT	DATE	TYPE	Rho	rh'	rh''	hr'

V CERTIFICATION: This is to certify that the Hospital Number on this sheet corresponds with Hospital Number on Patient's Chart.

____ Tech.

*Pathologist, St. Luke's Memorial Hospital, Racine, Wisconsin.

ST. LUKE'S HOSPITAL, RACINE, WISCONSIN

DATE	PATIENT* Type	Rho	Rh'	Rh''	hr'	hr''	DONOR Type	Rh	No.	HOSP. No.**	RECORDER	URINE FOR FREE HGB	REACTION SYMPTOMS	HEMOLYSIS

* Obtain this information from the patient's chart, not from the information on the unit of blood that is to be transfused.

** The hospital number on unit of blood to be transfused must be the same as the number on the patient's chart. Check if correct.

NAME _____ Rm _____ Doctor _____ Case No _____

Fig. 2. Record of Transfusions Form

the blood sample was taken from the proper patient, and that the results of the tests were entered in the proper clinical record.

When a transfusion is to be given, one of our own blood-bank personnel delivers the unit of blood. Before this is done, however, the blood type of the patient scheduled to receive the transfusion is entered in the first column on our record of transfusions form (Fig. 2). This information must be obtained from the patient's record, which we know is correct because of the earlier certifications.

The donor's blood type is recorded in the second column of the record of transfusions form. This information is taken from the data recorded on the tag attached to the unit of blood (Fig. 3). It must be obvious to the messenger that the blood is apparently compatible, even if we did not perform a cross-match. (We do an indirect Coombs cross-match routinely.)

The hospital number on the unit of blood that is delivered must correspond to the hospital number on the patient's record as noted in the third column. When all of these steps have been taken, they are certified by initialing in the "recorder" column.

When we are completely certain the blood selected for transfusion is compatible with the patient, the blood is delivered to the bedside. Here again the hospital number on the unit of blood is checked, and must correspond to the hospital number on the patient's wrist band.

If the patient is in surgery, the chart is obtained from the anesthetist and the data is completed. We do not leave blood with other personnel in surgery in the hope

(*Continued on page* 66)

Recipient _____ Hospital No. _____

Room No. _____ Physician _____

DANGER

The person administering this blood must certify that:

1. The Donor No. on this card and the Donor No. on the bottle are identical.
2. The Hospital No. and name on this card are identical with the Hospital No. and name on the recipients identification band.

Date _____ Signed _____

LABORATORY

Recipient Group _____ Rh _____ Donor No. _____

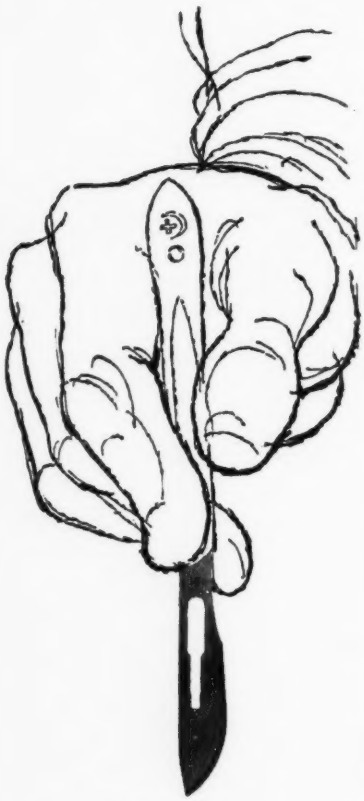
Protein Crossmatch _____ Signed _____

Coomb's Crossmatch _____

WARD SUPERVISOR

Complete the reverse side of this card and return it to the Clinical Laboratory.

Fig. 3. Tag attached to unit of blood. Reverse side has space for noting time of transfusion, patient reactions.



satisfactory to surgeon and budget

The surgical staff's most exacting demands are satisfied by the keener edge, better balance and greater weight of Crescent Blades.

The budget benefits by savings of up to one-third made possible by Crescent Blades.

TRY before you BUY. Send for free sample.

Crescent Surgical Sales Co., Inc.
48-41 Van Dam Street
Long Island City, New York

Crescent

surgical blades and handles

Amsco...

Sonic Energy Systems

Method-engineered for the fast, critical cleaning of surgical instruments, syringes and related items

Isn't it time your hospital studied the benefits of this advanced technic?

Write for newly-published technical brochure MC-564

·AMSCO·
ELECTRONICS

Division of AMERICAN STERILIZER COMPANY · Erie, Pa.

World's largest designer and manufacturer of Sterilizers, Surgical Tables, Lights and related technical equipment

NEW...HILOW RECOVERY BED

by Hill-Rom

for special needs in recovery rooms labor rooms and treatment rooms

In addition to its basic uses in the post-operative recovery room and labor room, this new Hill-Rom Recovery Bed is also proving highly valuable as an emergency delivery bed, for the treatment of eye cases, head and face injuries, and other cases requiring special therapy.

A manual hilow bed, it may easily be raised to treatment table height, and lowered when indicated to promote patient safety. The head end may be removed to facilitate care of eye cases or head injuries. The foot end is removable so that knee crutches or leg holders may be used on the labor bed.

Full length aluminum side guards are permanently attached to the bed, so that they will be immediately available when needed. Wrap-around bumpers protect walls and door jams. The IV Rod is stored on the bed. Swivel locks and brakes are on opposing 6 inch conductive rubber casters. The Trendelenburg Spring permits easy adjustment to any normally desired position. There are six locations where the IV Rod can be used. The foam mattress is covered with a conductive rubber sheeting.

For complete information on the Hill-Rom Hilow Recovery Bed, write for this booklet.

HILL-ROM COMPANY INC. · BATESVILLE, INDIANA

TRANSFUSIONS

(*Continued from page 64*)

that they will deliver the blood to the right patient.

As a final check, the person who actually starts the transfusion must certify that the donor number on the tag corresponds to the donor number on the unit of blood, and that the hospital number and name on the tag are identical with the hospital number and name on the recipient's identification band.

The first urine specimen that can be obtained after the transfusion is examined for free hemoglobin. Bloody specimens are centrifuged. Otherwise, a mere gross inspection is all that is required as a rule.

We have a special request form for this specimen of urine so that it will not be lost in the routine laboratory work. This form is made out by the blood-bank personnel, and the results of the examination are recorded in the fifth column of the record of transfusions form (Fig. 2).

We sometimes experienced difficulty in obtaining this urine specimen from the ward. The difficulty was overcome by rubber-stamping the order directly on the physician's order sheet.

When a transfusion is to be started, a notice is attached to the patient's chart to remind the ward personnel that the blood requested is at the patient's bedside. This notice form is printed on a bright pink paper stock to make it particularly noticeable.

Each of the steps we have outlined was instituted when it became clear that we could not always depend on other personnel.

Our system of checks and rechecks is elaborate, true, but the mere fact that the same items must be noted several different times makes each item more important to the person handling the blood. The elaborate checks are doing the job for which they were originally designed – protecting the patient throughout his contact with the blood bank. Our own personnel follow through on the entire procedure. We do not believe responsibility can be delegated with any degree of success in blood banking.

Pediatrics

OB DEPARTMENT

Feeding Solids to Newborns

[Because both obstetrics and pediatrics staffs are interested in the subject covered in this article, the two departments are combined this month for a discussion of a rather different concept of infant feeding.]

Feeding solid foods at two to three days of age and using a six-hour feeding schedule for newborn infants seem like rather revolutionary ideas to most obstetrical and pediatric personnel. But to Walter W. Sackett, Jr., M.D., Miami pediatrician, and William C. Roche, M.D., Gnadenhutten, O., they are well established methods whose merit has been proved by several years of use.

Neither knew about the other's results. Each gradually evolved his routine on the basis of observations during years of practice.

DR. SACKETT'S RESULTS

Since 1949 many of the babies under Dr. Sackett's care have been started on a six-hour feeding schedule at the hospital and have been introduced to solid food in the form of cereal at the age of two and three days. By the time babies are nine weeks of age, they may be enjoying a full breakfast that may include bacon and scrambled eggs.

At the 1959 convention of the American Medical Association, Dr. Sackett presented a scientific exhibit reporting on his results with the use of this concept in 1,040 babies (see picture). The infants showed normal progress and steady weight gain.

Hospital infant feeding schedules for Dr. Sackett's patients are based on the hours of 6-12-6-12. These hours were selected as being the most workable ones in keeping with hospital routine. The baby is offered the bottle or breast, according to the mother's wishes. The regular hospital formula is used for formula-fed babies.

At two to three days of life, the baby is given cereal at 12 noon and at 12 midnight, again because this is the most convenient time for nurses to get out on the floor and teach mothers how to give the cereal.

Nurses have found that the thicker the cereal is, the better it is taken by the babies. In the hospital the nurses routinely prepare it in the consistency of putty. Never have they found a baby unable to take and swallow it.

Dr. Sackett stresses to mothers that nothing be given between feedings except water, which is offered three times daily (midmorning, midafternoon, and mid-evening.)

On arriving home, the cereal time is changed to 6 a.m. and 6 p.m., to conform to the average family program.

Dr. Sackett is a firm believer in letting the baby know right away that he is not the boss – the parents are. "Do you want a happy baby? Then frustrate him a little," are the opening words in his *Manual on Baby Feeding*. He believes that a baby can learn to adjust quite happily to a strict routine with longer intervals between feedings. He also believes that babies should be cuddled when they are happy—not when they are crying.

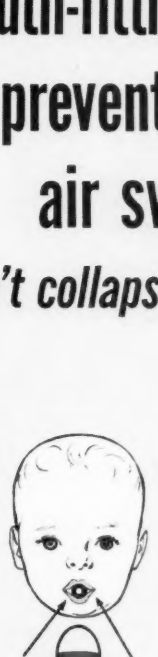
At the age of 10 days, the noontime vegetable feeding is begun. At 14 days, strained meats are offered either at noon, along with the vegetables, or at 6 p.m. At 17 days, the soups and the meat and vegetable combinations, such as lamb and rice or beef and

(Continued on page 69)

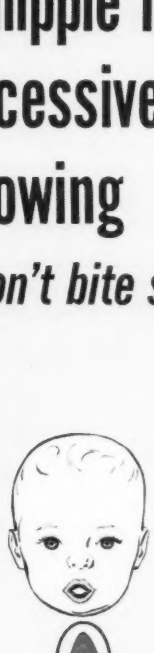
new... ..mouth-fitting nipple helps prevent excessive air swallowing

—won't collapse, won't bite shut

Clinically proved with both normal and hard-to-feed babies, lasts twice as long as ordinary nipples. Available in complete "Sure-Grip" nurser. Contoured CURITY bottle provides exceptionally firm grip. Square shape stores better.



Ordinary, bell-shaped nipple lets air in at corners. Often collapses and pinches shut. Ordinary nipple requires "push-pull" action to start feeding and insertion is often too deep for newborn. Rubber is frequently too tough to permit easy sucking action.



Oval-shaped Rib Nipple helps seal out air. Hollow ribs assure flow, won't bite shut. The Rib Nipple allows gentle "twist action" to start feeding for newborn. Premies take more formula. Less burping, less colic. Rubber is soft, yet withstands repeated washing.

Special help for common problems. Sluggish eaters get a full feeding with less effort through the Rib Nipple. With the prompting of "twist action", premies take and hold more. And cleft palate feeding is seldom a problem.

Improves normal feeding action. With the Rib Nipple, the baby doesn't eat too fast. Less spitting up. Supplementary feedings for the breast-fed are easier. The soft, functional shape allows smoother feeding with new as well as older babies.

Curity® Rib Nipple

THE KENDALL COMPANY • BAUER & BLACK DIVISION

vegetables, are introduced, and the baby is now eating regular little meals. The midnight feeding may be dropped at this time, says Dr. Sackett, "having fully served its purpose, which was to pacify not the infant but his jittery father, anxious mother, grandparents, neighbors, and doubting friends. Many babies, to my knowledge, have gone without the midnight feedings either from birth or shortly thereafter with no untoward effects."

Why the opposition to very early feeding of solids? Dr. Sackett, in his manual, comments:

"In this eagerness to discourage early feedings of solids, many authorities forget the numbers of allergic babies who are raised entirely on such foods as barley formula, soybean milk, or meat formula, all of which run far afield from milk, and which are merely these same solids which we advocate given in liquid form. In view of this, can you think of any real reason why infants may not be fed these same foods, as well as other solids, in conjunction with adequate water between meals, which would give the same end result as a nonmilk formula?"

There has been criticism of his concept of feeding. The Miami pediatrician pointed out several years ago that the criticism centered on four main points: (1) question of nursing, (2) frequency of allergies, (3) question of the baby's ability to swallow and assimilate these foods, and (4) allegation of the omission of the opportunity to manifest parental love. He has answers to all of these criticisms.

(1) The percentage of mothers nursing successfully is no lower than it was when he used a four-hour schedule, and the mothers who nurse have no more difficulty going six hours between feedings than did nursing mothers during the war, who after returning to work often nursed their infants only morning and evening.

(2) With the early introduction and rotation of foods, there should be fewer allergies. "Indeed, what could have more allergenic potentialities than a diet restricted for months to one single food substance such as milk, other than the mother's own milk," Dr. Sackett pointed out.

(3) He has found no inability on the part of mothers to feed solids from a spoon when they start practically at birth. This is in direct contrast, he emphasized, to the trouble his patients used to have when they waited until six or eight weeks to start solids. Nor has there been any problem of assimilation by the infants.

(4) Dr. Sackett says he urges his patients to fondle, cuddle, love and rock their babies, but only when they are happy and not when they are crying. He believes that granting a child what it wants when it cries – even if it is only food – fosters a definite pattern of demand which will be continued throughout childhood.

The possibility of choking on solid foods is another question frequently raised. Dr. Sackett's opinion is that most babies choke on vomitus at one time or another, regardless of the type of food taken in, and that milk curds, as in vomited gastric contents, can cause more trouble than the much smaller homogenized particles of the so-called solid foods.

More than three years ago Dr. Sackett listed 10 advantages of this schedule:

(1) Fewer growing problems are encountered as these babies grow, probably because they are taught almost from birth that there are other foods besides milk.

(2) There is an easy acceptance of food from a spoon, because they are fed from a spoon at two days of age.

(3) The use of vitamins and mineral supplements is optional, and often may be unnecessary because the infants receive the minerals and vitamins in their food.

(4) Parents are happier and more emotionally stable than the parents exposed to a "demand philosophy" of feeding.

(5) The babies are far happier and more contented and become independent and learn to amuse themselves early because they are left to their own devices.

(6) If one doubts the wisdom of continuing a high lipid or cholesterol diet throughout childhood and adulthood, this routine is a solution. By the twelfth month of age most of the babies are taking a very limited amount of this oft-termed "unnatural food"—milk.

(7) Many doctors in Florida using this schedule have noticed a decrease in the incidence of diarrhea, which they attribute to the immediate consumption of the contents of each bottle at each feeding rather than doling out its contents over a longer period of time, at the baby's whim.

(8) Many mothers believe there are increased health and developmental benefits derived from its use. Dr. Sackett is naturally reluctant to accept this thesis, and is content to say that they are just as healthy as babies fed on other schedules.

(Continued on next page)

Dr. Walter M. Sackett, Jr., is shown here discussing his concept of feeding infants solid food. Photo illustrates results of introducing early solid feedings to 1,040 babies and was taken in the scientific exhibits section, 1959 AMA convention in Atlantic City.

(9) The schedule allows for a better relationship between other children in the family and the baby, because the baby does not demand most of the mother's care and attention.

(10) Inquiries from many foreign countries, concerning the use of solid foods native to each country in place of more expensive importations of canned milk, impressed him with the feasibility of substituting such foods in areas where milk is unavailable, or even where a baby is allergic to milk.

Here is the six-hour feeding schedule, as included in Dr. Sackett's manual:

Six-Hour Feeding Schedule†

Feeding at 6-12-6-12 (or 7-1-7-1, etc.): Offer water between feedings but nothing between midnight and 6 a.m.

At 2-3 days: Cereal at 6 a.m. and 6 p.m. (12 noon-12 midnight in hospital). Thick as putty. Oatmeal, barley suggested as starters.

At 10 days: Strained vegetables at 12 noon. (Peas, beans, carrots suggested as starters.)

At 14 days: Strained meats (either at noon or 6 p.m.).

At 17 days: Soups; meat-vegetable combinations.

Midnight Feeding: May be dropped at any time.

†This concise schedule may be removed and posted in the nursery or kitchen.

Then aim toward feeding:

Breakfast	7-9
Lunch	12-2
Dinner	5-7

At Weekly Intervals Add:

3 weeks: Orange juice and water, equal parts of each, at breakfast time, preceding cereal. Other juices later.

4 weeks: Concentrated Cod Liver Oil—2 drops a day to start—increase 1 drop a month up to 5 drops daily.

5 weeks: Egg (soft-scrambled, coddled, or hard-boiled egg yolk).

6 weeks: Strained fruits at 6 p.m.

7 weeks: Mashed banana—very ripe.

8 weeks: Custard, puddings.

9 weeks: Crisp bacon (well crumbled).

Suggested Formula:

Evap. Milk	2	7	10	9	14*	10
Water	3	11	14	12	18	12

↓ Going home formula

↓ Hospital formula

For cereal where nursing

All new foods are started at one teaspoon and subsequently increased rapidly. Fill the baby at each feeding. Do not make more than one change daily; i.e., new foods or change in formula. Unless otherwise instructed, start meals with solid foods.

*This actually represents 1 large can of evaporated milk which is poured into a quart container, which is then filled with water.

DR. ROCHE'S RESULTS

At an institute on maternity nursing in Bloomington, Ind., in 1959, an obstetrical supervisor enthusiastically told other nurse registrants about results obtained by Dr. Roche with use of a six-hour feeding schedule and introduction of solid food on the third day. Even premature infants are placed on the schedule after they reach five pounds in weight.

"Don't the babies spit up the cereal?" the other nurses wanted to know. No more than they spit up milk, said Grace Warrington, supervisor at Twin City Hospital, Dennison, O. And they seemed to cry less between feedings, she added, probably because they weren't hungry.

Dr. Roche, when HOSPITAL TOPICS requested further information, reported the following observations on use of the schedule in more than 450 infants:

1. At three to four weeks the infant sleeps through the night satisfactorily, and takes only three feedings daily.

2. The infant is fed solid food with a spoon. It is not given through an enlarged nipple. The mothers are encouraged to use a training cup for the formula after eight to 10 weeks. Ten minutes is allowed for the formula and 10 for the solid food.

3. Colic, constipation, and diarrhea are rare, and are usually corrected by slight adjustment of foods.

4. Babies are contented. Frequently they have to be awakened at feeding time.

5. They gain weight steadily and are well-devel-

(Continued on page 98)

EXPLOSION-PROOF ★ THERMOSTAT CONTROL

STERILE SOLUTION WARMER

The only explosion-proof surgical heating unit of its kind. Proven throughout the nation as a low cost multi-purpose piece of equipment designed to save time and effort in operating rooms and wards alike. Once the basin containing the heated sterile solution is placed in its receptacle, the warmer's heating element maintains constant temperature until the basin is removed.

This leaves the circulating nurse to be more efficiently utilized in other phases of the operation.

Adjustable thermostat control keeps solution at fixed temperature indefinitely.

Approved by Underwriters' Laboratories for explosive atmosphere

THE Lin COMPANY • P. O. BOX 247 CLINTON, OKLA.

Cat. No. 100-160 (illustrated), with 32 oz. irrigating bottle.
Cat. No. 100-162, without irrigating bottle.

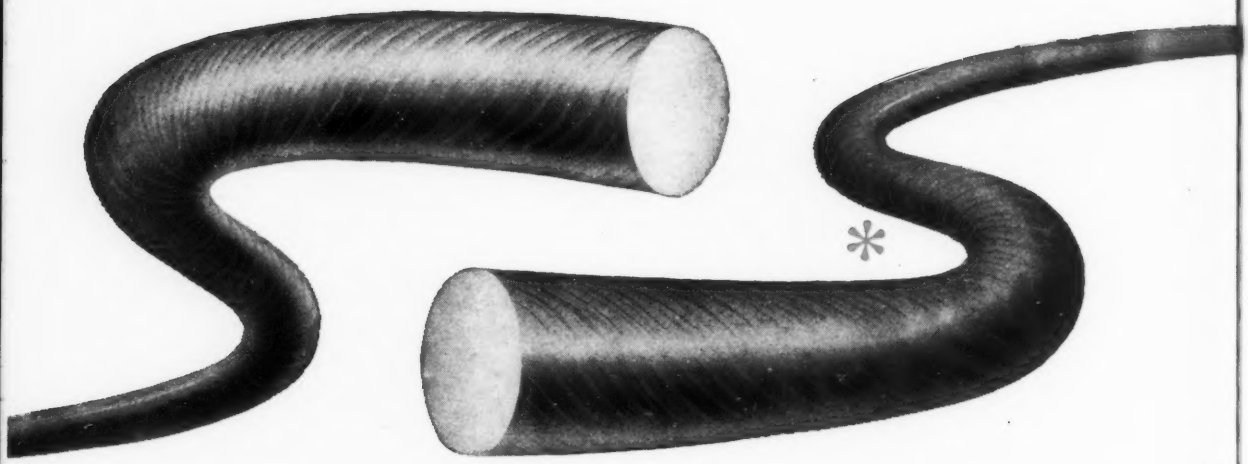
improved model SKLAR electric evacuator for Wangensteen Technique

The improved Sklar Electric Evacuator meets every demand for continuous, low grade suction and pressure. It may be regulated to meet the individual patient's requirements; thus, assuring maximum comfort and highly satisfactory clinical results. The Sklar Electric Evacuator is designed specifically for finely controlled, continuous suction and pressure in such procedures as: stomach evacuation, intestinal decompression, thoracic drainage, prostatectomy, gastric lavage, fistula drainage, and bladder irrigation. The versatility of this new model eliminates the need for highly specialized equipment. **No maintenance or lubrication required — guaranteed for two years.** Available through Sklar Surgical Supply Distributors. Send for descriptive literature and specifications.

SKLAR PRODUCT

J. Sklar Manufacturing Co., 38-04 Woodside Avenue, Long Island City 4, New York

they may look the same...but



one suture is more pliable

Electron Beam Sterilization preserves the natural elasticity of collagen. As a result Electron Beam Sterilized ETHICON surgical gut is more pliable, and averages about 10 per cent stronger, too.

* electron beam sterilized surgical gut

ETHICON®

the OR

Orienting Fourth-Year Medical Students to the Technics, Environment and Responsibilities of the Operating Room

By Rose Tashjian*

Each year we have some 50 to 60 medical students from the Harvard University Medical School at the Peter Bent Brigham Hospital for their clinical experience in surgery. This two-month experience in a teaching hospital is required of fourth-year students, and the entire class is divided among the Massachusetts General Hospital, Beth Israel Hospital, and this hospital.

A number of the students in this category have had some exposure to surgery in their curriculum, since in their second year of medical school they can choose surgery and practice in the experimental laboratory. Though they are keenly aware of the difference between that exposure and the experience of working in an atmosphere created for the human patient, they are generally unaware of the factors that make up this special environment and the technics practiced within it.

An orientation program is planned by Francis D. Moore, M.D., surgeon-in-chief. As part of this program the nursing service in the operating room has the responsibility of orienting the students to the operating room.

We set aside time during their first day at the hospital for part of the orientation period in order to:

1. Familiarize the student with the role that he plays as an assistant to the surgical team in regard to the patient.
2. Guide the student in practicing good aseptic technic.
3. Familarize him with the policies and interpersonnel relations in the hospital operating room.

During this hour and one-half session in the operating-room suite, the following points are included by informal lecture, demonstration and discussion:

The author demonstrates to a young medical student the correct technic for donning gown and gloves. Good operation-room conduct is stressed, and occasional air and mask samples taken to prove that unnecessary conversation increases the bacteria count.

1. Introduction of the students to the operating room supervisor by the chief resident. The supervisor in turn presents her assistant and the operating-room secretary. This simple gesture enables the student to recognize those who can help him.

2. Explanation of the operating-room physical plan, including a tour of the operating-room suite, the recovery room, cystoscopy area, anesthesia area, the restricted and unrestricted areas. During this tour, there is a discussion on the psychological aspect of the preoperative patient and the nursing

(Continued on next page)

*Operating room supervisor, Peter Bent Brigham Hospital, Boston, Mass.

Above, the student observes the demonstration of the surgical scrub technic. Later he will be observed as he demonstrates the meticulous procedure for the evaluation of the instructor.

Below, Miss Tashjian and student go over a copy of the routine followed by the hospital. A copy is given to each member of the orientation class, and each is expected to be letter-perfect in following it.

care of the patient during his postoperative period in the recovery room. Also, there is an opportunity to introduce these students to the nurses and other members of the operating-room staff and to inform them of the contribution of these persons to the function and management of the operating room.

3. Explanation of clothing policies. It is reiterated that students must change completely into operating-room clothing before entering the suite, and must wear conductive shoes which must be clean. Students are instructed in the use of the germicidal shoe bath and told that their shoes are to be worn only in the operating-room area, and left in their lockers.

4. Safety practices. This portion includes instructions and reasons for wearing only cotton outer clothing (because other materials create static), and for caring for conductive shoes and making the daily check with the Conductometer to assure they are safe. Students are also acquainted with the electrical system with its ground detector, and with the technics described in testing the floors and furniture, which are checked for conductivity each month by the maintenance staff.

5. Environmental sepsis. The students are impressed with their responsibility to the patients in that they can be a source of possible infection. They are responsible for reporting any upper respiratory infection to the resident and the operating-room supervisor, who will see to it that they are given nose and throat cultures. It is also emphasized that dermatitis problems, open cuts, and lesions should be reported immediately.

In these and other ways students are made acutely aware that there is a standard; that they are going to be an important part of it, and must make specific contributions to seeing that the standard is maintained at the highest possible level.

6. Operating-room schedule. Students are shown where the schedule is posted and where to find their own names and informed of their responsibility for checking again before scrubbing to note any time change.

7. Individual responsibility. Covered in this discussion are the student's responsibility for aseptic technic; his responsibility to the surgeon and the patient on the table; his duties in cooperating with other members of the team; the importance of promptness; time allowed for scrubbing and being ready for duty, taking into consideration the effect of delay on the patient's condition and the surgeon's state of mind.

8. Surgical scrub demonstration. Correct technic is explained and shown, and each student is given a copy of the routine followed in the hospital.

9. Donning gown and gloves. Correct technic is demonstrated, and an explanation of sterile areas is given.

10. Maintaining good aseptic technic. Once the students have donned gown and gloves, they are instructed in good operating-room conduct. Occasionally, air and mask samples are taken to prove that unnecessary conversation increases the bacteria count.

11. Septic cases. The students are told what cases are considered septic and their responsibility in these situations. Emphasis is given to the necessity for immediate isolation and sterilization of equipment and care of the room.

We have found that the time is most profitably spent in helping these students become acquainted with operating-room nursing, maintaining our standards, and accelerating their adjustment to the new environment.

Mental Health in the Operating Room

By Grace T Gould, R.N.*

A rich potential for mental health exists in the operating room. The O.R. offers a unique quality of human group experience to be found nowhere else in the hospital. For this reason I hope operating-room experience is never deleted from the nursing curriculum.

To some persons, the operating room is perhaps the last place they would expect to find mental-health concepts and their application. I believe such thinking is due to a stereotype of the operating-room area and the operating-room nurse.

In this stereotype, the operating room is supposed to be a mechanical, technical area, and the operating-room nurse is a person who possesses primarily mechanical, technical skills. My own experience has been that nothing could be farther from the truth.

To begin with, I don't believe you have to apologize for your technical skills. You need all of them. What would the surgeon, the anesthetist, and the patient do if you were not technically competent? Thank heaven you have these skills.

Furthermore, technical skills foster and are interrelated with human-relations skills. I have heard patients say: "I feel safer, just watching the way that nurse puts on her sterile clothes." And I remember the elderly gentleman who, while waiting in the induction room, looked through the open door into the operating room and was quite impressed by the efficiency of the busy people he saw. He said: "You folks sure seem to know what you're doing; you can put me to sleep now any time."

I think the technical skills are needed because they make the patient and the staff feel secure. But the fact that one has technical skills does not mean that one does not also have human relationship skills; and these interact.

For instance, you can go in and set up a *room* — or you can go in and prepare a room for the human beings who will live some of the most important moments of their lives in that room.

And doesn't it make a difference, when you are setting up the room, for whom you are setting

(Continued on next page)

*The author, a psychiatric nurse, is now employed by the Division of Mental Health, Department of Institutions, State of Washington. She was formerly a member of the faculty, Texas Woman's University College of Nursing, in Denton, Tex. This paper is based on a talk at the 1960 meeting of the Texas Association of Operating Room Nurses.

it up? The wife of a surgeon? Your sister? The head nurse on a medical ward? Your next-door neighbor?

Mental health has to do with people. People are important; the people we know and the people we don't know. Basic to everything that we would talk about in terms of mental health in the operating room is our concept of man. Who is he, and what is he? Who is the patient, and the patient's family?

The operating room is a good place to learn anatomy and physiology. It's also a good place to learn profound respect for the human being and the human body.

I remember hearing a nursing student complaining about mopping up some blood on the floor. She thought this was the job of the porter, who was off that day. I guess she didn't consider the job worthy of her. I said, "You know, that's human blood you're mopping up – not a pig's or a cow's blood. The specimen that you carry to the lab; the lining of a uterus after a D&C; a phalanx of a finger, an arm, or a leg – these all belonged to a human being; they were once part of him. If you believe a human life is sacred, then this specimen is sacred, because God made the person and the specimen."

You handle specimens differently when you feel this way, and you help those who are working with you to handle them differently when they see your example.

Mental health actually begins with a deep, reverent respect for the person, and for all parts of him. If you love someone, every hair on his head and every pore is precious and important to you. Why do you think people save baby curls? And everybody we take care of is precious and important to someone. They may not be wives of directors on the board, but they're all "V.I.P.'s."

For the first time we feel very hopeful about reaching this goal of mental health. And you in the operating-room have an enormous opportunity for prevention of mental illness. We know that a person's past experiences very much affect his present experiences. We know that what happens to us in the present affects the future. In the continuum of living it's hard to know where the past and the present and the future begin and end. But here's your opportunity.

First of all, what happens to the patient and his family and to the staff; to the operating-room team; to everyone concerned? We're not interested only in the mental health of the patient and the family. Your mental health is important, too. You have to be in quite good condition to work as hard as you do, and you have to be reasonably comfortable and happy, or you can't create a comfortable environment for other people.

Did it ever strike you that you can break into the vicious cycle of the past, the present and the future?

If we are today what our past has created us, then we're victims of our past. If what happens to us today determines how we react in the future, then the present is the only hope you have for change, for modifying behavior, for attitudes. This is the rationale behind all preventive medicine. What we do today can modify the trauma of yesterday and prevent some of the trauma of tomorrow.

We know this about mental illness: people get mentally sick or sick in any way because of the things that have happened to them, because of the experiences they've lived through – maybe from the moment of conception to the present.

Treatment and cause are related. If you're sick because of the experiences you've had, doesn't it seem logical that you can get well because of the healthy experiences you'll have?

This is where there is a great opportunity, in the operating room, to intervene in the present. Did you ever stop to think how little the operating-room schedule or bulletin board tells you about the situation or the person? It gives you the room number; the surgeon's name; the anesthetist's; the name of the operation; the patient's name. But how much does it tell you about anybody whose name is mentioned? And about anything that's going on? Did you ever stop to think that only the name of the operation is the same? That one cholecystectomy to you may be another thing to me?

There's no such thing as routine surgery. Surgery interrupts anybody's life routine. There's no such thing as minor surgery, either. It's all major, if it's being done on *you*.

How little that board tells you. It doesn't tell you that the surgeon's wife is in labor in the OB department that morning – and he's supposed to be calm, cool and collected. Nor does it tell you that the circulating nurse or the scrub nurse has dysmenorrhea. It doesn't tell you who was on call all night; that it may be the first scrub for the day shift – but it's the last one if you've been there all night!

It doesn't tell you a great deal about the patient. Incidentally, it's just as easy to learn his name as the name of his operation. You don't have to learn 15 or 20 names like someone in a ward. There's going to be only one patient in this room; you should learn his name as you learn the name of your surgeon and anesthetist and your circulating nurse.

It doesn't tell you what kind of night that patient had. Perhaps they gave her a Seconal at 9 o'clock, and then woke her up for the physical, and woke her again for the "prep."

There are no small operations or minor operations when it's you or someone in your family. Have you ever watched a nurse on the O.R. staff change when someone she knows well is having surgery? She is especially concerned with the sterile field and the drapes and the light; hopes to get a certain anesthetist; wants a certain nurse to circulate and another one to scrub.

The board doesn't tell you about the family

of the patient. It doesn't tell you who the patient is and what he does; what kind of year he's had; whether he lost his job before surgery; whether this is the fifth in a series of operations, and he's so tired of all of these surgical procedures.

It doesn't say that he just got over another serious illness and before he could get on his feet again he came down with this! It doesn't tell you about all the things he's suffering from or the kind of person he is. He's just a name on a board.

We look at patients as though they arrived by spontaneous combustion; as though they were always patients and always will be patients! Where were they before – a day before – a week ago? What will they be afterward? How does this episode fit into the total life experience?

Maybe you can't, in your situation, know the patient before he comes up, or know his family. But isn't it comforting for the patient to see a familiar face. It's satisfying to be able to say, "I'll be here when you wake up." This is reassuring, too; it implies he's going to wake up.

Patients have many fears that are quite natural. One which anybody facing any kind of surgery has is the fear that maybe he will die.

Those of us who aren't in the operating area have the greatest respect for operating-room nurses. We don't know how you even keep up with the new technics; the new equipment; the new machines, the new ideas, the new procedures.

Years ago, who ever thought we'd be operating on an open human heart? But one thing that isn't new, that hasn't changed, is the human heart. We're doing new technics but on the same human body. Operating-rooms and operating-room procedures have changed dramatically and been revolutionized in the last 5, 10, 20 years – but the babies born today are the same kind of flesh and blood that they were 20 years ago!

We're working on the same old human body – and even with all of our marvelous technics there is still the possibility that the patient won't pull through.

There are also people who fear that maybe they will live! Some people with a malignant or terminal process hope they won't pull through.

Then there are two opposing fears which usually co-exist. First, the patient has a fear of pain, and a fear of expressing suffering; a fear of not "being able to take it" and a fear of not "being tough enough."

Patients are afraid that maybe they won't be "knocked out enough," especially with a local; that suddenly they're going to feel pain, sharp or excruciating pain for which they may not be prepared, or that perhaps a spray of Novocain isn't going to get down deep enough.

Then there is the fear that co-exists: that they will have too much anesthetic – that it will be so deep that they won't wake up. This is related to the fear of death and also to a fear that many may have in surgery – loss of control, being totally and completely dependent on other people who are usually strangers.

The O.R. is a strange world. For you who work in it, the green or the white gown, and a certain kind of shoes, and the lights and the instruments and the noises, are commonplace, everyday. But this is a strange world, a bizarre world, even for a very sophisticated patient. After he has passed that swinging door into the operating-room suite, he is separated from people he knows and loves and they're separated from him. He's alone, and defenseless with strangers.

Another erroneous idea, I think, is concerned with preoperative medication. We feel rather sure that the patient is comfortable because he's had preoperative medication, but he's not moving much and he's not talking much. He's quiet.

Some patients are comfortable, and some are not. For instance, I remember seeing patients who wanted to ask a question, but because they were slowed down because of preoperative medication they couldn't quite formulate it. But it was in their mind, and then later they didn't know whether they said it out loud or just thought it.

A patient told me that when she had a "spinal," about 10 years ago, she heard the surgeon say, "See, I got in the wrong place, I'll have to try again." The thought vaguely went through her mind that maybe she could be paralyzed or something, from the way it sounded.

This was not a deliberately cruel or mean thing to say; it was thoughtless but very natural, because most of the patients the O.R. team works with are unconscious patients. Because surgeons and operating-room nurses are used to patients not being consciously aware of them, often it's natural to treat the conscious patient as though he were unconscious, or to give much too much credit to the effectiveness of preoperative medication; to think that he's not quite with us, that he's not really listening; not really absorbing the stimuli in his environment.

We've learned that sounds may be exaggerated, things may seem more bizarre; that the patient is suffering more but often isn't able to talk about it or to move.

In many hospitals patients are anesthetized in an induction room and never are in the operating room when they are conscious – but this does not happen everywhere.

Patients have described a feeling of helplessness, of being strapped down. One patient said, "Why, I almost felt crucified. Here I was with the IV and I was stretched out and I couldn't move; I never felt so helpless in my whole life! But you know, something wonderful happened. The nurse who was walking around the room took the time to hold my hand for those few seconds until I fell asleep."

(Continued on next page)

It was only a few seconds. And she never released her hand until she felt the patient's hand let go, and she knew he was asleep. You might think that wasn't important nursing care. But that patient will never forget that nurse as long as he lives.

We have an erroneous idea in nursing that to do anything big or effective we have to spend a lot of time with a patient. As students, we think, "Well, after we do this procedure, we'll talk to them." After we meet the physical needs if we have a couple of minutes left over we'll throw in some of the emotional needs!

You don't have a lot of time in the operating room. You are the busiest group of nurses I know anywhere! You scoot; you run; you look as if you're on roller skates or maybe wings. You move fast and work fast. Time is a luxury you don't have.

An O.R. nurse may say, "You barely clean up one room and they move the next one in! I haven't even opened this pack yet! What do they think I am, twins?"

Or the circulating nurse: "I'm covering two rooms! I need roller skates!" Maybe it's three rooms, or more. However, you don't need a lot of time for a mentally healthy environment in the operating room. It takes only a second to wink, to smile, to pat the foot of the patient waiting on the stretcher outside, or to look at him and say "Hello! Good morning!" Let him know what's going on. You're not going to get into a big conversation with him. It wouldn't be good for him. You want to keep him quiet. Besides, you don't have time. But you can say, "Did you get any rest last night? How are you this morning?" Maybe you are wearing sterile gloves – you can still wave good morning!

The idea is to let him know you're not just interested in instruments, you're interested in *him*. And you're getting the instruments and the room set up in good shape *for* him, because you want things to be safe and secure.

You're not doing it just to keep on developing manual skills, to see how dexterous you are; how fast you can do it. It's not a game. You're doing it to protect him – to protect his family.

Incidentally, you know, surgery is hard on the families. They didn't get any preoperative medication; they didn't have a Seconal the night before. They're facing it cold; they're getting this experience straight. Do you know how long it is when you wait? Look at their faces as you come through the door: "How are they doing? How much longer?"

Time's going fast for you; you're working hard, you're passing, you're doing a thousand things at once and thinking of what you're going to do next. But they just stand and watch the hands of a clock go around. And they pray: "Just let him pull through! I don't want to raise three children alone." Or, "They're supposed to be real good now. I wish I could have talked to the surgeon before they started." Or, "If anyone would just come out and let me know! Even to know that they're in; or if they're closing, or how much longer."

They're afraid to even go to the bathroom – for fear that while they're away someone may come out to give them a report!

I have said to relatives, "It's going to be a while yet and everything's going fine – why don't you go down to the coffee shop and get a cup of coffee?"

And their answer has been, "But, if they come out while I'm down there they'll think I've gone home!"

I have known people who wouldn't sit down for fear they would be out of the line of vision of the people going and coming through the O.R. suite!

We say: "The patient is a family; and the family is your patient." This "patient" is having a rough time because it isn't getting much pharmacological assistance; therefore it must get emotional assistance.

Moreover, our operations are taking longer now. We didn't used to have someone under surgery from five to eight hours; now we do. But have we thought that the relatives are waiting a lot longer now than they used to wait?

Have you looked through the little window into the recovery room? You feel as though you want to go through it, and cover a patient with the sheet, and hold a restless patient, or be there when the patient wakes up.

Many hospitals have worked out some understanding and exceedingly kind ways of communicating with families during surgery. The kind of communication they have has a lot to do with the mental health of family members as they go through this experience. How will they feel about future surgery? Will they want to come back to the hospital?

Many persons put off operations at the cost of their lives because of unfortunate previous experiences. I've heard people say, "No more surgery for me!" To the warning, "It's a little tumor now, it's nothing; if you wait it may cost you. . ." they answer, "Well, I don't *care!* No more surgery for me!"

But if those persons could come in and have a first-rate human experience, they could face surgery again in the future, and could help others to face it.

Look at the implications for health teaching, if these persons told others, "You ought to go to that hospital, those people know what they're doing! They were nicer to me than anyone has ever been before!" Other people who had feared surgery might be influenced to get health services – to be hospitalized – to dare to have surgery!

But mental-health concepts are not just for patients and families. They're for everybody. Unfortunately, we may try to apply these concepts with patients but not with each other.

Do you know how the other members of the team are feeling when they come to work? Take the surgeon. It's one thing to hand a scalpel; it's another to use it. When you've made an incision in a human being from here to here, and somebody's insides are staring you in the face – no matter how many times you've done it, it takes something out of you. It's rough! You have life-and-death responsibility.

We have stereotypes for surgeons, too. The surgeon is supposed to be "temperamental." And if he is, he may have good reason to be.

One approach for dealing with the surgeon's temperament may be the way a mature, experienced nurse replied to a surgeon who was issuing a tirade that would have made a Marine blush. She knew this surgeon almost as well as she knew her own son. She said: "Honey, you just go ahead and swear, if it makes you feel better."

Then there is another possible reply to this kind of explosion, "It's been a rough morning, hasn't it; you didn't get much sleep last night either." Suddenly the surgeon thinks, "Well, they understand a little bit; they know I'm blowing off steam. They aren't taking it personally."

If you can do this for him, there might be a day when you can let off a little steam too! "They're always late! Where is everybody? Who do they think I am, quintuplets?"

Then he can say: "Are you getting any more help? Did that requisition come back with what you want? Anything I can do to help?" Support begets support. It's contagious.

Many other nurses envy operating-room nurses. Some of them see you as leading a very glamorous life. But what they envy most, perhaps, is your close contact not only with patients but with staff. Nowhere in the hospital, perhaps, is the team more of a reality. You literally touch the elbow, the side, of the physician, the surgeon. There's no doubt that you're a team. You're all in the same room together; you have the advantage of proximity. You're physically close, and when you're physically close it's easier to be psychologically and emotionally close. It's easier to understand each other, to know what people are thinking and feeling and to be able to meet their needs.

I think sometimes other nurses envy you the fact that when the doctor puts his hand out, you put the instrument in it. You're *that* close. You do it without even thinking.

Some nurses today are very dissatisfied because they've gotten so far away not only from the bedside of the patient, but from the doctors. We aren't even making rounds with doctors any more in some hospitals. They make their rounds and we make ours. It used to be that the physician always had the nurse at his side.

I believe that that is where nurses want to be. Traditionally, that's how our profession came into being: "to assist" the physician; to be there when he needs us; to support him, to comfort him.

Can it be that we've become so independent that we almost resent the physician's intrusion in our nursing work?

Perhaps you don't face this problem in the same degree and extent that people face it in the wards; you're close to the doctor. You are a real team; you are giving students and staff an opportunity to learn group skills that they could not learn in other ways.

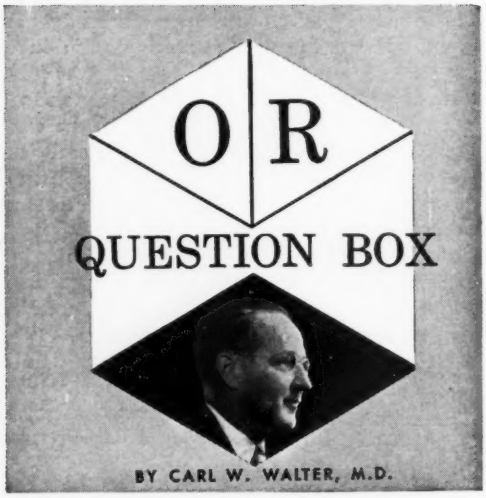
Where else do you get *this* group of professional people working together with the same patient–for this long a period of time – with this quality of human group experience and teamwork?

This can be a growing experience; a reassuring experience – because mental health is very much concerned not only with the individual but with the group, and with group living, and group working together.

I think that you in operating-room nursing have given the rest of us a very shining example of loyalty. For the most part, you may get furious with anesthetists and surgeons, but no one from any other part of the hospital had better say a word about them! *You* can criticize them, but no one else can – just as we can talk about our own relatives – but no one else had better. You are loyal to the physician, and I think he is loyal to you. You have a rapport that I believe many of us in other places wish we had. I think there are good reasons why you have it.

Patient, nurse, O.R. team – all want and need mentally healthful experiences – and they are to be found in the operating room.

"You have been impartially selected for our executive training program."



Assisted by Dorothy W. Errera, R.N.

Q. What is the Lane technic?

A. The Lane technic is a super-refinement of aseptic technic. It is a "no touch" technic used in the early 1900's by Sir Arbuthnot Lane, a British orthopedic surgeon. Instruments are used once and discarded; fingers are never allowed in the wound; tissues and bone are handled only with sterile instruments. It is a good technic for surgery when carcinoma is present because it prevents implants of malignant cells in the wound, but it is not essential for clean cases in a modern operating room. It is used in only a few hospitals in the United States.

Q. Do you think there is any difference in results if sponges are kept soaking in 70 percent alcohol or wet with alcohol from a bottle just before the skin is cleaned for an injection?

A. Cotton sponges moistened with alcohol are effective for disinfecting the skin site of an injection. They can either be immersed in alcohol or wet at the time of use with the solution in a squeeze bottle. The latter technic may be more wasteful, and, unless care is taken, the sponge may be only superficially moistened.

When this technic is used, sponges should be sterilized before immersion in alcohol or packaging in canisters. They should be large enough to provide a good cleaning surface. Wisps of cotton used in many hospitals for cleaning the skin for injection or vein puncture are useless. Transfer forceps should be used for removing sponges from stock containers so that residual supplies are not loaded with bacteria from fingers. Containers for alcohol should have snug closures so that evaporation is minimized and germicidal concentration remains bactericidal.

Q. Should a case considered contaminated or dirty in the operating room be admitted to the clean recovery room? It has been our policy to return such cases directly to the floor.

A. The first consideration is safety for the patient. If concentrated nursing care is not available for the postoperative patient in his own room, then recovery-room care should not be sidestepped.

The environment can be protected from heavy contamination. A waterproof, occlusive dressing applied at the end of surgery will contain the greatest source of dangerous organisms. If single room facilities are not available in the recovery room, the patient is placed in a curtained cubicle, in a bed or litter made up with fresh linen. For the rest of his stay in the recovery room, the linen should be changed only if absolutely necessary.

Transmission of infection is controlled as in any other communicable disease, with meticulous hand hygiene, dressing technics designed to protect personnel and the environment, careful disposal of excreta, terminal sterilization in heat of instruments and equipment, and so forth. When the patient is discharged from the recovery room, the floor in the area of his bed is sanitized with a detergent-germicide. Cubicle curtains are carefully removed for laundering, and the bed sanitized with a detergent-germicide or live steam.

Q. We are now resterilizing all goods every 30 days. Do you recommend dating bundles prior to sterilization or after sterilization?

A. To minimize destruction from superheating, all sterile packs must be disassembled and textile and rubber components hydrated with distilled water (or by laundering) before resterilization. The double-thickness muslin wrapper, used so that four thicknesses cover a package's contents, is a good bacterial barrier, and if supplies are stored in clean, dry, vermin-free places, there is little justification in perpetuating the expense and destruction inherent in resterilization.

Inventories of sterile equipment can be maintained so that shelf stock is always that most recently sterilized. In instances when equipment may not be used for many weeks or months, the sterile package is wrapped in a plastic or paper wrapper to protect the sterilizing wrapper from dust.

Dating was originally a technic for recognizing supplies which had been sterilized. Recently, a pressure-sensitive sealing tape has outmoded this technic. Markings in the tape become apparent only after exposure to steam at 250° F. for a minimum of 15 minutes. While not intended in any sense as a sterility indicator, the tape does signify that the package and its contents have been exposed to steam within the bactericidal temperature range for the minimal time allowed for destruction of bacteria.

Personnel are conditioned to look for this change in the tape as they were once conditioned to look for a date before accepting a package as sterile.

Central supply rooms are too often undisciplined jungles of equipment and people. If packages are dated or marked in any manner, it should be done as supplies are removed from the autoclave, to avoid the inevitable mixing of sterile with unsterile supplies.

SELECTED BIBLIOGRAPHY

By Dorothy W. Errera, R.N.

Anderson, Kevin: "Pseudomonas Pyocyaneus Disseminated from an Air-Cooling Apparatus." *Med. J. of Australia* 1:529, April 18, 1959.

A stream of air from a cooling system passed close enough to the operating table to arouse concern in staff members, and cultures of the air were requested. A blood agar plate was held in the air stream for three minutes. The plate was incubated overnight and yielded a profuse growth of *Pseudomonas pyocyaneus.*

The cooling system consisted of a rotating drum covered with a porous material. The drum dipped into a trough of water which was kept at a constant level. An electric fan pulled air through the drum into the room for evaporative cooling. The cooling water was cultured, and pour plates showed that 0.1 ml. grew organisms too numerous to count, and direct plating of the water yielded heavy growths of *Pseudomonas pyocyaneus.*

The trough was cleaned and the water replaced with a 1:2000 solution of chlorhexidine made in sterile water. The drum cover was soaked with the germicide, and the apparatus was quarantined. After resumption of service, subsequent cultures revealed no contamination. The author suggests that chlorhexidine be added at regular intervals to the water in the trough.

Sakson, John A.: "A Simple, Inexpensive Debridement Stand." *AMA Arch. Surg.* 80:305, February, 1960.

A debridement pan that can be made in the hospital workshop simply and inexpensively is described. Needed for its construction are:

1. An old bedside stand or Mayo with adjustable height.
2. An ordinary baking pan, 14 x 10 x 4 ($1.49).
3. Four inches of ¾" copper pipe.
4. Chrome-plated refrigerated grill shelf (49c).
5. Screw hook for suspending bucket.

Directions: (1) Cut tray of stand to fit bottom of baking pan; (2) drill hole through pan and tray; (3) solder ¾" copper pipe to hole, and (4) suspend bucket under tray on hook to catch irrigating solution.

E. G. Rees Jones: "A Screen for Use During Thoracic Operations." *Lancet* 1:1392, June 25, 1960.

A screen is described which allows unrestricted access to the patient's face and keeps assistants off the patient's face and neck. It is a rectangle of wood 10 x 22", faced with Formica. The rectangle is attached to a knuckle joint with a fore and aft tilt of 270°, and the joint is attached on a pillar 20" long.

The whole device is clamped to the side rail of the table behind the head of the patient, who is in the lateral position. It is moved up or down or tilted until the position is correct and is then draped.

Clinical Anesthesia Conference: "Postoperative Neomycin Respiratory Depression." *N. Y. J. Med.* 60:1977, June 15, 1960.

The operating-room nurse might add to her patient-radar the subject of preoperative antibiotics. Certain of these in combination with anesthesia cause respiratory depression from paralysis of skeletal muscle. Neomycin has been proven to be one such depressant, and it is strongly suspected that streptomycin and dihydrostreptomycin may also be such antagonists.

Time Tried

DIACK CONTROLS

Since 1909

"Diack Controls,
Like safety switches,
Save lives (and
wounds, and many
stitches)".

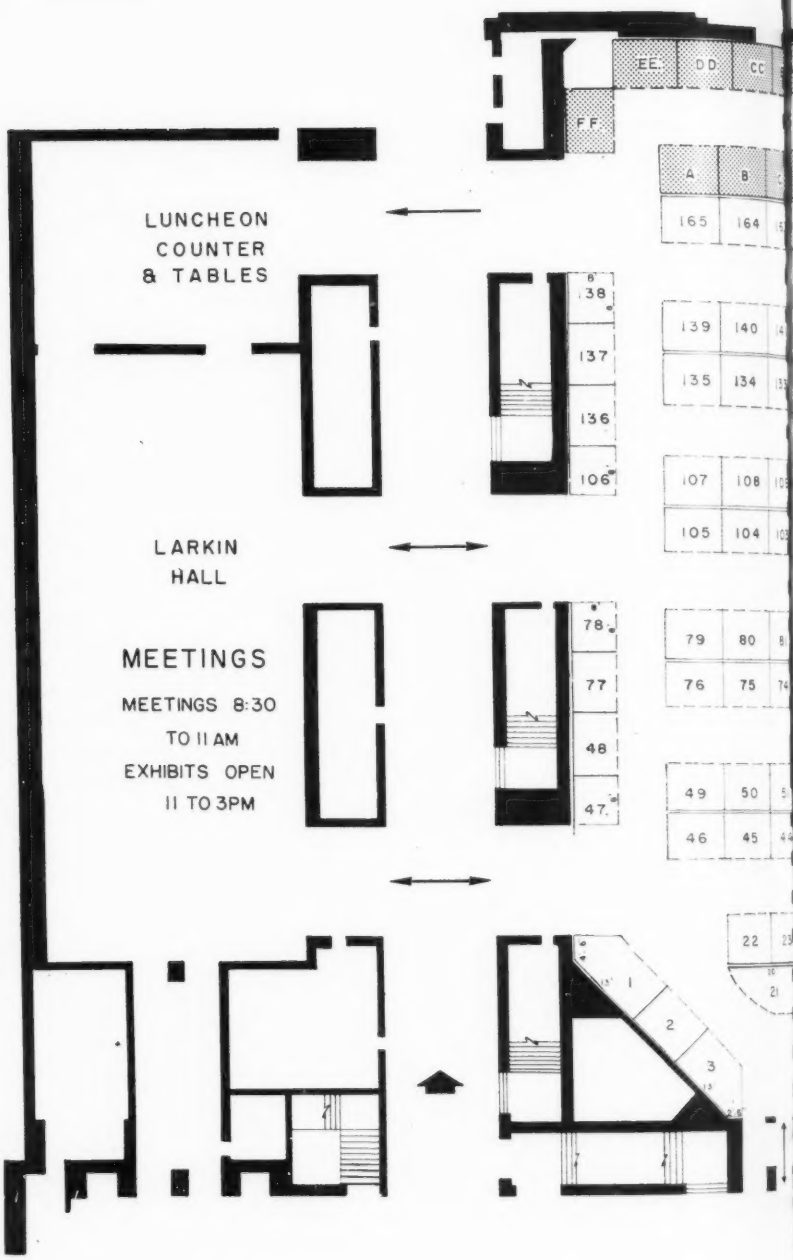
Go back to the first principles of cleanliness and sterility and you will control the staph problem.

SMITH & UNDERWOOD, Royal Oak, Michigan . . . Sole manufacturers of Diack Controls and Inform Controls

AORN Congress

Colorful San Francisco will be the scene of the 8th national congress of the Association of Operating Room Nurses. The dates: Feb. 13-17, 1961. Plans are well underway for the program and advance information on program participants will be released in October.

Once again, an important part of the congress will be the technical exhibits. The following are planning to exhibit:



A.S.R. Products Co.
Abbott Laboratories
Acme Cotton Products Co., Inc.
Aeroplast Corp.
American Cyanamid Co.,
Surgical Products Div.
American Cystoscope Makers, Inc.
American Hospital Supply Corp.
American Sterilizer Co.
Anchor Products Co.
Aseptic-Thermo Indicator Co.
Austenal Co.

C. R. Bard, Inc.
Don Baxter, Inc.
Bard-Parker Co.
Becton, Dickinson & Co.
S. Blickman, Inc.
The John Bunn Corp.

Wilmot Castle Co.
Chesebrough-Pond's, Inc.
Chilean Iodine Educational Bureau, Inc.
Clay Adams, Inc.
Coca-Cola Co.
Codman & Shurtleff, Inc.
Conco Surgical Products, Inc.
Conductive Shoe Co.
Cutter Laboratories

Davol Rubber Co.
J. A. Deknatel & Son, Inc.
DePuy Mfg. Co., Inc.

Dittmar & Penn Corp.
Doho Chemical Corp.
Duke Laboratories, Inc.

Eaton Laboratories
Eisele & Co.
Ethicon, Inc.

The Fengel Corp.

Gomco Surgical Mfg. Corp.
The B. F. Goodrich Co.
Gorman-Rupp Industries, Inc.
Guardian Chemical Corp.
Gudebrod Bros. Silk Co., Inc.

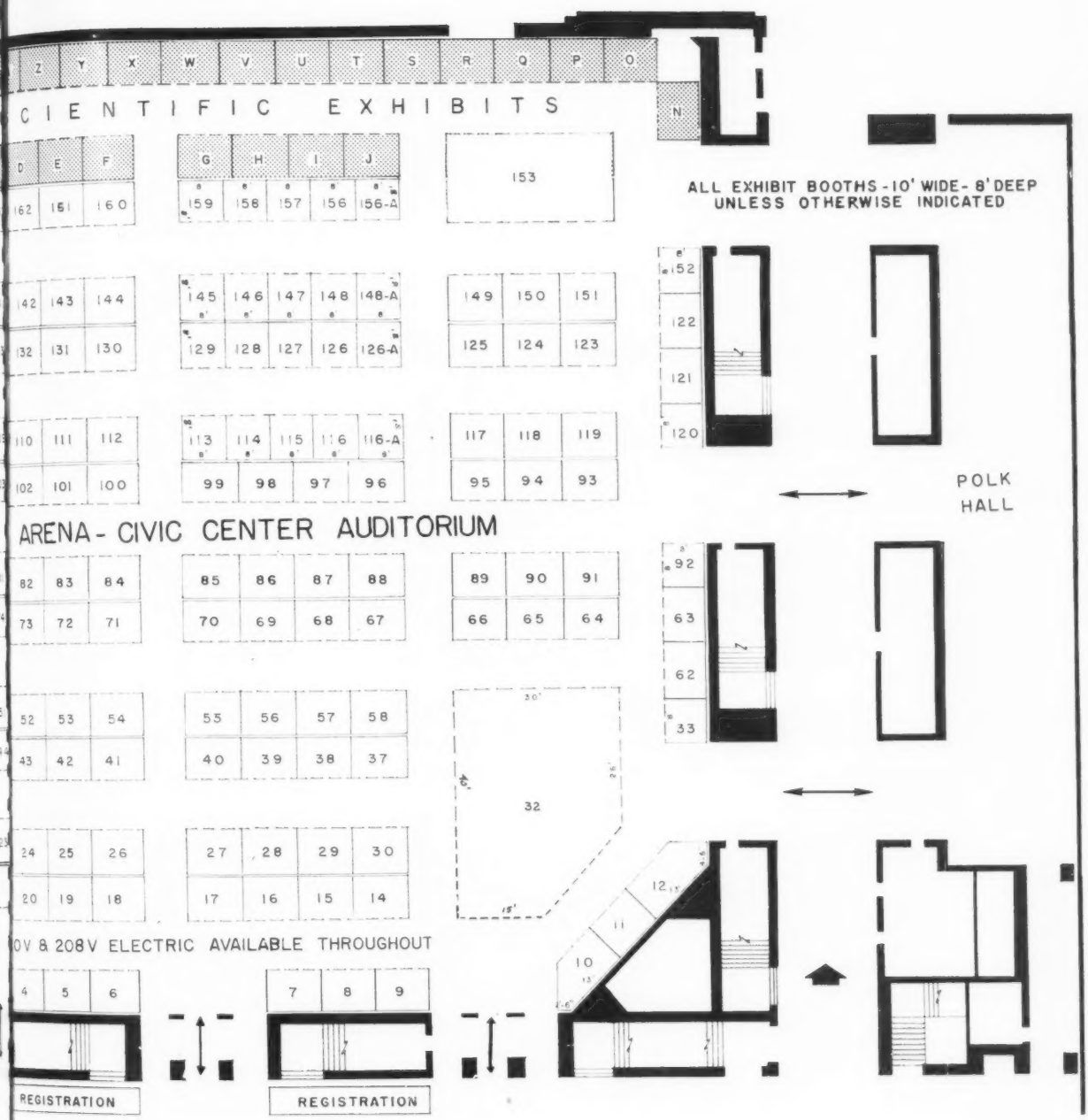
Hausted Division—Simmons Co.
Homer Higgs Associates, Inc.
Hollister, Inc.
Hypo Surgical Supply Corp.

Ipco Hospital Supply Corp.

Johnson & Johnson

The Kendall Co. (Bauer & Black Div.)

The Lawton Co., Inc.
Lehn & Fink Products Corp.
The Lin Co.
The Lorvic Corp.



The MacBick Co.
The Massillon Rubber Co.
Meinecke & Co.
Minnesota Mining & Mfg. Co.
V. Mueller & Co.

O.E.M. Corp.
O R Products Co.
Ohio Chemical & Surgical Equipment Co.
Orthopedic Equipment Co.
Orthopedic Frame Co.

Parke Davis & Co.
The Perry Rubber Co.
Personal Products Corp.
Pharmaseal Laboratories

The Pioneer Rubber Co.
J. T. Posey Co.
Pratt Hospital Equipment Co.

Randall Faichney Corp.
Richards Mfg. Co., Inc.
Ritter Co., Inc.
Will Ross, Inc.
Rotary Hospital Equipment Corp.

The Seamless Rubber Co.
Shampaine Co.
J. Sklar Mfg. Co.
Smith & Underwood
Snowden-Pencer Corp.
E. R. Squibb & Sons
Sterilmaster Co.

Sterilon Corp.
Steriphane Corp. of America
Storz Instrument Co.

Tailby-Nason Co.
Travenol Laboratories, Inc.

United Surgical Supplies Co., Inc.

A. G. Verdolyack, Inc.

West Chemical Products, Inc.
Edward Weck & Co.
Wester Bros.
Winthrop Laboratories

Zimmer Mfg. Co.

Transistors, Battery Take Patient's Temperature

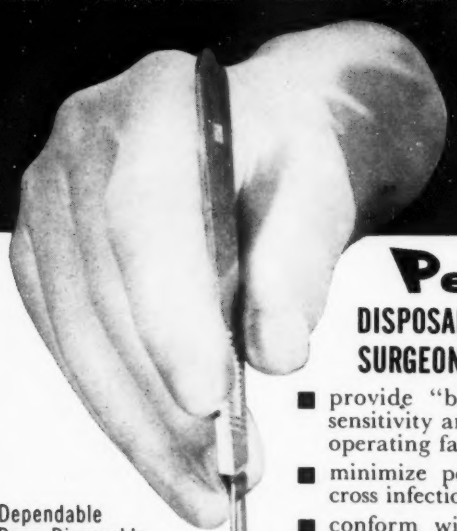
With the installation of a new electronic device, the nurse on general duty can take her patients' temperatures without stirring from the nurses' station.

The new gadget is a clinical electronic thermometer, developed by Dr. D. C. Simpson of the medical physics unit at Edinburgh University, Edinburgh, Scotland.

It consists of a meter, a switch and highly sensitive thermistors, or probes. The electrical resistance of the thermistor changes when heat is applied to it. It can be strapped to the patient and connected by wires to the central temperature reading point, where resistance of the thermistor is measured and the temperature indicated on a dial.

Dr. Simpson states that the number of probes that can be connected to the meter is unlimited, so that the nurse in charge can obtain individual temperatures in both Fahrenheit and Centigrade.

Perry DISPOSABLE Latex Surgeons' Gloves are SAFE! CUT COSTS, SAVE TIME AND LABOR



Perry DISPOSABLE LATEX SURGEONS' GLOVES

- provide "bare hand" sensitivity and minimal operating fatigue.
- minimize possibility of cross infection.
- conform with government specifications ZZ-G-421, Amendment 4.
- are available in white or brown, sizes 6 to 9, including half-sizes.
- are furnished with envelope of Bio-Sorb® dusting powder for your convenience.

Dependable Perry Disposable gloves eliminate laundering, sorting, testing, mating and wrapping. The easy-open Perry-Pack® with "Scotch" brand autoclave indicator tape is instantly ready for sterilization.

Bio-Sorb is a registered trademark of Ethicon, Inc.

For samples and further information, write: Dept. P

Perry RUBBER COMPANY

MASSILLON, OHIO

A Subsidiary of United Industrial Corporation 2454

"Useless" Appendix Has Role Against Infection

The much-maligned appendix, long considered useless, may play an important role in the body's defense against infection, according to Dieter Sussdorf, immunologist at the California Institute of Technology, Pasadena.

The appendix has been found to be rich in lymphoid cells capable of producing disease-fighting antibodies. It may also help protect body defenses from damage by radiation such as x-rays or the rays given off in a nuclear explosion.

Paralysis of the body's antibody producing mechanism is a major cause of radiation death. Germs invade the body and, with no antibodies to arrest their growth, multiply uncontrolled.

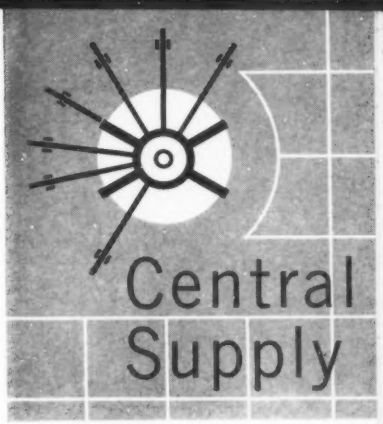
Straitjacketed Rats Develop Ulcers

After 20 hours of confinement in straitjackets, every one of 300 rats in a University of Oklahoma experiment developed ulcers due to stress.

Dr. Rene Menguy, assistant professor of surgery at the university, states that the rats didn't like the straitjackets at all, and fought, bit, and glared at the researchers. Being an extremely active animal (a caged rat will cover ten miles a day), the restraining jackets constituted a severe form of stress.

During this period of stress, Dr. Menguy adds, there was a complete suppression of acid secretions, which seemingly proves that ulcers produced by stress are not due to hyperacidity.

Cutting the vagus nerves leading to the stomachs of the distressed ratts seemed to protect them. This could indicate, according to Dr. Menguy, that the ulcers of stress are due to increased nervous stimulation reaching the stomach by way of the vagus nerves.



Making Better Utilization of People and Materials

By Marie Dzupin, R.N.*

The two most essential components of any central service department, irrespective of size, are *people* and *things*.

At a recent regional hospital convention which I attended, three points emphasized were: the continuing rising cost of hospital operation – eight percent this past year; the fact that the hospital service is no longer bed-centered but is becoming literally a workshop with an increasing number of diagnostic and laboratory procedures per patient – from the former average of four procedures to the present average of 14 procedures per admission; and the fact that Americans are a mobile population and the move is westward and suburban.

Because of the continuing rise in costs of hospital operation and the increasing number of diagnostic procedures being performed, it is especially necessary for the central service supervisor to be aware of the efficiency and economy with which she operates her department.

Salaries, physical facilities and supplies constitute the greatest percentage of the cost of operation. Personnel salaries also constitute approximately 66 percent of the total cost of operating the department.

Auxiliary or nonprofessional personnel make up most of the present-day hospital service team. They are quickly becoming a career group of employees. It behooves supervisors to give thoughtful consideration to the training and performance of these workers, so that their best utilization will be realized.

Who are the workers in the central service department? In most instances, with the exception of the supervisor and her alternate, all workers are non-professional people. In the community setting they could be grandparents, mothers with children ranging from infants to adolescents, an unmarried worker 17 to 65 years of age, and all, to a greater degree, people who have had some work experience in other than a hospital setting.

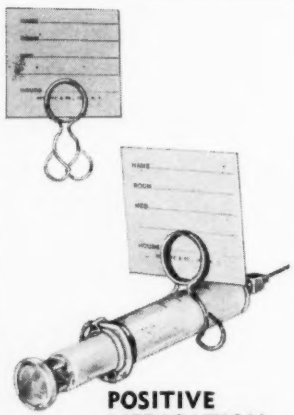
Thus, we find workers in many stages of experience, background and ability. When we need an additional worker or receive a replacement on the staff, we are immediately confronted with the task of preparing the worker for his role. This task is paramount because efficiency is derived only through good employee relationship, which is created only through proper preparation of both old and new employees.

(Continued on next page)

*Nurse consultant, Technical Projects Division, American Sterilizer Co., Erie, Pa.

This article is taken from a paper given before the annual program meeting of the Massachusetts Association of Central Service Supervisors, Boston, March 31, 1960.

Meinecke
helps you serve
more patients, better



POSITIVE
MEDICATION
IDENTIFICATION

Meinecke's exclusive
SYRINGE
MEDICINE CARD
CLIPS

- keep medicine card securely attached to syringe . . . card and syringe cannot become separated even if tray is tipped
- REDUCE DANGER OF POSSIBLE MIX-UP IN MEDICATION
- CAN BE USED WITH ANY TYPE OF TRAY
- hold loaded syringe level in elevated, sterile position on *any smooth, rigid surface* . . both needle and plunger ends are kept free from contamination
- fits either 2 cc. or 5 cc. syringe interchangeably
- lasts indefinitely . . . attractively plated spring brass clip never loses its tension
- simple to attach . . . just insert medicine card in coil at top of clip, press clip down over syringe barrel until legs lock into position

D-205 Syringe Medicine Card Clips
Packed 1 doz. to an envelope:
Lots of 12 doz. ..... $2.40 doz.
Smaller quantities ..... $2.60 doz.

Meinecke & COMPANY, INC.

Over 65 years of continuous service to the hospitals of America

211 Varick St. • New York 14

Branches: Los Angeles & Sunnyvale, Calif., Dallas, Chicago and Columbia, S. C.

Preparation of the worker is endless. It begins with and should not end with the orientatioin program. However, it is not our purpose to discuss the planning of an orientation program. Essentially, we shall deal with appraisal of the employees' work habits. No other factor contributes as much to the efficiency, economy of operation, and quality of service rendered by the department than employees with good work habits.

Understanding where these habits come from is one of the keys to improving them. Each habit the employee displays may stem from: (a) his early training, education, family; (b) his first experience at work; (c) the group of people he is assigned to work with – who may be either casual or industrious; (d) the quality of instruction he receives in preparing him for his work, along with the degree of supervision.

There are many ways in which a supervisor can change the work habits of her staff. Occasionally one act can cause the change; in some instances many tactics must be employed. Each situation will probably need to be approached in a different manner. Too, it is wiser for us to confront only the work habits associated with immediate job performance rather than attempting to correlate habits the employee may exhibit away from the work situation.

What we do then, as supervisors, is to take an objective approach to the main point – work performance.

Here are eight rules which can be followed to improve the work habits of your staff:

2. Observe the work pattern of each employee.

All tasks in the central service department, whether they be simple or complicated, eventually fall into a repetitive category. In many instances the work patterns are not logically contrived and are frequently of the employees' own devising. The patterns may then be carried out day in and day out without thought, consuming too much precious time. Occasionally, we find a worker who putters and is concerned with trivial details not essential to the method, hence gets little accomplished.

We must observe also whether shuffling and duplication are occurring. Lack of equipment or work space may contribute to reshuffling or back-tracking in work flow.

It is not difficult to think of several such examples. How often have you seen a worker wheel a cart loaded with soiled material into the central service department, and take the articles off the cart and place them onto a drainboard or work table, from which they are then moved into the sink for washing, then onto the opposite drainboard or work counter for draining? The items are then dried and placed on a table across from the drainboard for wrapping or then moved to a cart and transported to a farther wrapping area.

Much rehandling and movement could be eliminated if the worker would remove the soiled items from the cart and place them directly into the washing sink. After they have been washed and drained, they can be dried and placed directly onto another cart and transported to the wrapping area.

Another example: Have you observed a worker lifting gloves out of a washer in mounds, and walking several times to a work counter some distance away to remove the load from the washer? Or is he using a basin to receive the gloves as they are removed from the washer and transporting them to the work counter in one trip?

2. Substitute a good habit for a poor habit.

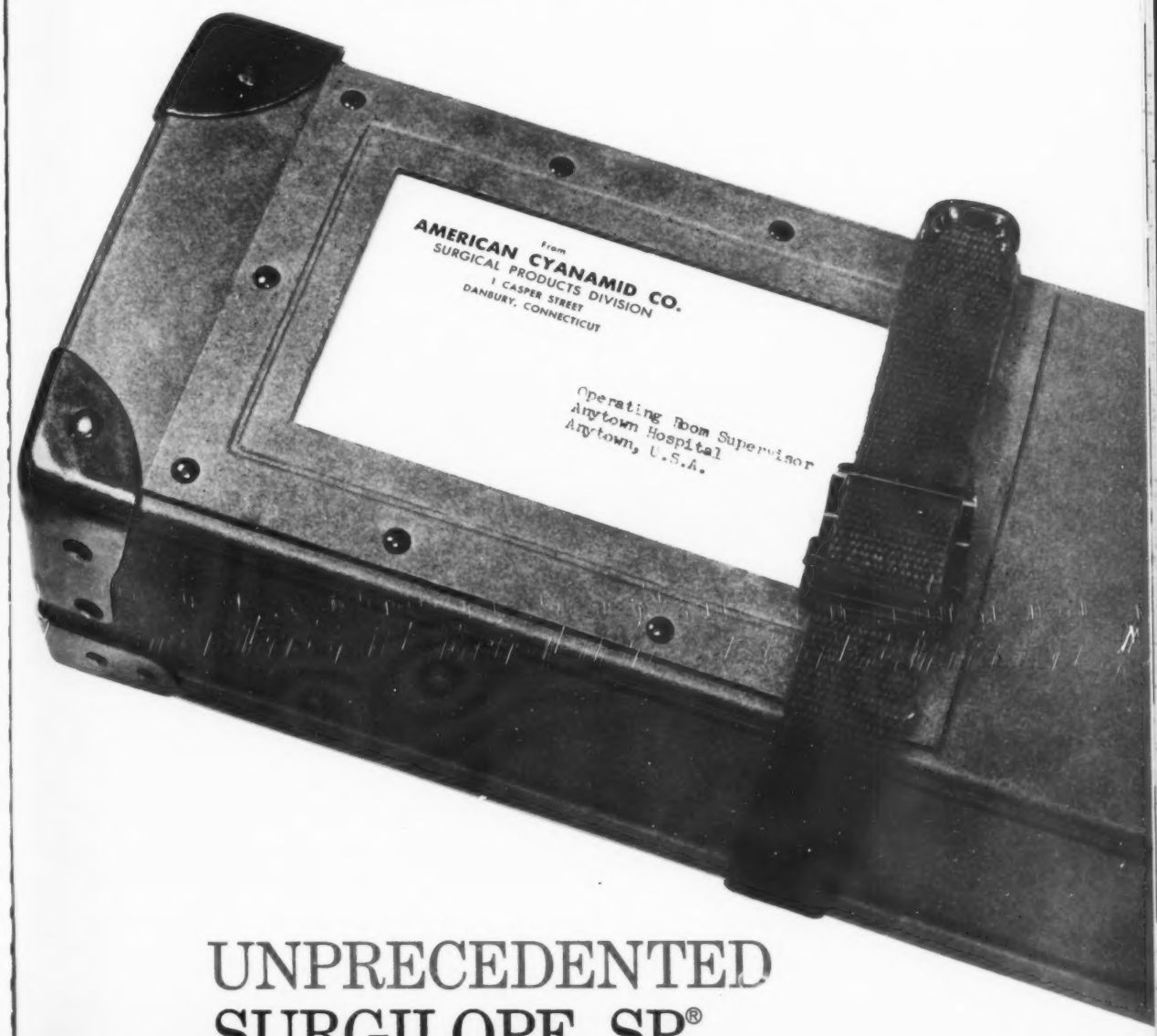
Analyze the work place used to carry out a particular task. Why is the worker moving about, carrying a partially assembled tray from work area to work area? Analyze the method. The processing of a particular item may be described in steps. The problem may be in the way syringes are being handled before they are racked for washing in the washer, or being packaged for sterilization.

What is the worker doing with the linen delivered to the depart-

(Continued on page 91)

CYANAMID

SURGICAL PRODUCTS DIVISION ANNOUNCES SIGNIFICANT NEW SAVINGS IN OPERATING ROOM MANAGEMENT!



UNPRECEDENTED SURGILOPE SP® SERVICE PROGRAM

CYANAMID

SURGICAL PRODUCTS DIVISION

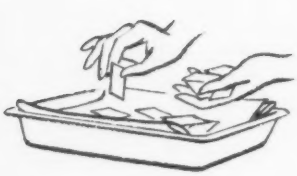
FIRST and only manufacturer to utilize the plastic double-envelope principle for safer, more convenient sterile suture packaging and dispensing.

NOW FIRST and only manufacturer to offer resterilization and repackaging of unused suture packages . . . at no extra cost to your hospital.

In a recent survey of O.R. nurses, Surgical Products Division learned two things. (1) There is a strong preference for the SURGILOPE SP® Sterile Suture Strip Pack compared to foil and other packaging because this suture pack is safer, provides more convenient dispensing, and offers a wide range of sutures and needles, permitting standardization. (2) Hospitals requested a means of totally eliminating the time, expense and potential hazards involved in cold resterilization of unused suture envelopes.

Now, with the new SP Service Program, Operating Room personnel no longer need to resterilize unused suture packages. Surgical Products Division assumes all responsibility for repackaging and resterilizing suture packages . . . saving the hospital many nurse-days each month. This program has been thoroughly tested in leading hospitals and has already been enthusiastically adopted in many areas.

THIS IS HOW IT WORKS

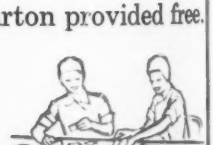


Unused inner envelopes are collected. Hospital suture resterilization procedures are eliminated.

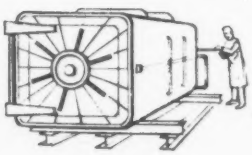
Sutures are returned to Surgical Products Division

in special mailing carton provided free.

Sutures from each hospital are separately reprocessed.

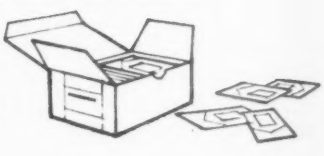


Sutures are resterilized



and repackaged by *individual* lot.

Hospital's original sutures are returned, certified sterile U. S. P.



For complete details write to Sales Office below, Attention: SP Service Program Dept.

Producers of Davis & Geck Sutures and VIM® Hypodermic Syringes and Needles

CYANAMID
AMERICAN CYANAMID COMPANY
SURGICAL PRODUCTS DIVISION
30 ROCKEFELLER PLAZA
NEW YORK, N. Y.

SALES OFFICE: DANBURY, CONN.

(Continued from page 88)

ment? How many times is a piece of linen rehandled and moved, from cart to table to shelf to table before being placed into a pack? Can some of the moves and rehandling be eliminated?

3. Get the new employee oriented to the right pattern of work immediately.

The instructing of new personnel is the responsibility first of the supervisor and, by her delegation, of other qualified staff members. What happens to the new employee if the supervisor does not fulfill her instructing responsibilities? He will do what other workers tell him to do—which might be wrong. This often is more disastrous than not doing the task at all. Overhearing what other workers tell each other about how the work is done is another way the new worker tries to apply himself to his new work situation.

By noting the way the new worker is trying to adapt himself to his new work situation we become very conscious of the fact that first impressions are important. The new worker is generally alert and wants to succeed. If he is oriented and instructed properly, he will learn the correct method and procedure the first time he encounters the task.

Have you defined your goal for introducing the worker to his learning program? Is it to help the worker become familiar with technics, processing procedures and pattern of operation of the department as related to total hospital organization?

As the worker is introduced to his learning program, try to appreciate how he feels. We have all felt afraid and insecure in a new situation. It takes time to learn skills, to acquire speed in doing a skill well, to feel free to ask and receive additional guidance when something is not clearly understood. By expecting too much too soon we often thwart the employee and fail to develop his potential. This results in a complete waste of time of the supervisor's instructing efforts.

People learn at different rates, and work output will vary. Sometimes the slowest learner at the start becomes the most proficient worker. Instruction and orientation of the new employee should not be entrusted to personnel whose work habits are poor or to persons who lack the ability to teach.

4. Define or demonstrate the reason for changing.

The new work pattern may benefit the employee in many ways. Pointing these out to him will further enhance the possibility of his carrying out the new method. When we cannot recognize his improvement in performance in a monetary way, demonstrate that the new method is less fatiguing and perhaps more interesting and easier to do, and contributes to better patient care.

5. Analyze and try the new method yourself.

By writing down the steps in the method, studying the arrangement of the work area, and actually performing the task yourself, you can better judge the ease with which the task may be performed and whether the steps involved are carried out in a logical manner. In other words, try doing some methods analysis of the task.

Whenever possible, observe the environmental conditions where the tasks will be done. Good lighting, adequate ventilation, proper working height, permitting alternate standing and sitting positions at the work area by providing sitting stools with back rests—all influence the learning pace of a new employee and productivity of all employees.

While revising our methods, we must bear in mind that the most important points for the worker to know in any task are what to do and how to do it. Knowing "why" is not essential for the functioning of the nonprofessional when he is being taught a proven method.

When the new worker is given the right start through a planned learning program, what effect does this have on the older employee, who may have learned his tasks through the eye-and-ear method? Will all of this guidance the new employee receives make the older employee feel insecure or threatened in any way? Has he been given the opportunity of learning the new procedure with guidance?

Often the analysis of a method

(Continued on next page)

FIGURE #1

CENTRAL SERVICE DISPENSING RECORD

MONTH April YEAR 1960 DIVISION 300 Main (Surgical)

ITEM	STD.	DATE 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	T
Syringe 2cc	64	23	32	51	40	42	42	46	46	43	51	23	46	28	19	19	25	25	35	36	30	31	24	35	37	45	32	29	53	35	35	
5cc	30																															
10cc	6																															
20cc	3																															
50cc	3																															
Insulin	3																															
Tuberculin	3																															
Needles 15 ga.	10																															
18 ga.	15																															
20 ga.	15																															
22 ga.	45																															
24 ga.	45																															
Gloves 7½	6																															
8	6																															
Rectal gloves	8																															
Medicine glass	2																															
Culture tube	2																															
Towels 1/pkg	6																															
Large cotton balls 3/pkg	10																															
Toppers 2/pkg	24																															
ABD 1/pkg	12																															
Dressing sets																																
9 A.M.	5																															
2 P.M.	5																															
9 P.M.	5																															
Catheter set																																
9 A.M.	5																															
2 A.M.	5																															
9 A.M.	5																															

FIGURE #2

CENTRAL SERVICE

SAMPLE - LEDGER SHEET TO CHECK RAW SUPPLY STANDARD

FOR OPERATION OF DEPARTMENT

Cabinet	Shelf	Item To Order	Type of Pkg.	Wkly. Qty.	May 12	19	26	June 2	9	16	23
A	6	Large cotton balls	2000/ case	1/ week							
B	6	Medium cotton balls	3000/ case	1q. 2/ weeks							
C	6	4 x 4 gauze toppers	3000/ case	1q. 4/ weeks							
D	6	3 x 3 gauze squares	4000/ case	1q. 2/ month							
E	6	Patient ready toppers	24 bx. to case	2/ weeks							

Fig. 1. Dispensing record for 2-cc syringes.

Fig. 2 (inset). Ledger sheet for checking and determining standard of raw supplies to be kept in stock.

creates an opportunity to let the older employee participate in changing the method, or to eliminate a feeling of insecurity by including him in the learning program — because there is a new method to learn for everyone. Periodic conferences in how to improve are fruitful.

6. Provide the good example.

The supervisor must set a good example for the worker. If you're stressing housekeeping, pick up that stray piece of paper as you pass by. If you make a small error, admit it. And if the employee makes an error, encourage him to do better. Help him analyze why he made it.

7. Set the work climate via informal organization.

Work habits and patterns are policed to a great degree by the group. If the worker becomes disinterested, assign him to a new, possibly more challenging task. Tediousness should be avoided wherever possible. It is advantageous to have more than one worker oriented to each task. Assignments can be rotated; operation is not interfered with during vacation and illness, and a change of pace is provided for all employees.

8. Encourage participation.

Solicit participation from the group regarding the way they are performing their tasks. In most instances the worker will contribute good suggestions. If the supervisor shows genuine interest in the views of the worker, the worker will do a better job and set a higher pace for work than might be expected.

The work habits your employees demonstrate reflect your leadership. Work habits can be changed only through good leadership.

MATERIALS

Now let us consider the other important component of the department: materials — dispensing materials, stock quantities needed for efficient processing in central service, and stock quantities for expediency of care of the patient on the nursing divisions.

Standard quantity distribution of supplies provides a simple method for the planning of material needs. Too little material in circulation often causes inefficiency in operation. For example, if there are only a small number of syringes and needles or catheterization trays in circulation and these are used often during any 24-hour period, it will be necessary to reprocess each tray or syringe almost immediately after use so that it may be available for the next patient requiring the treatment.

This can be expensive, because a worker is kept busy at frequent intervals getting this tray or item reprocessed, and in any type of processing the get-ready and put-away parts of the procedure require the most time. Also, if supplies are inadequate it will be difficult to organize the work in the department, because the workers will start and stop many tasks.

When less supplies are in circulation, more personnel are required around the clock to reprocess the items. When greater standards are in circulation, fewer personnel are required to reprocess, because there is less set-up time and less traveling time utilized for dispensing and return of the items. If adequate materials are available, better work organization and better utilization of personnel will result.

For instance, all soiled needles and syringes can be collected at a stated time. They are brought into the central service department, washed and packaged for sterilization. This processing of syringes and needles is then completed and will not be resumed until the next day. The same might apply to processing of other items such as gloves, external or topical solutions, wrapping of individual use dressings (if you wrap your own), wrapping catheters for the standard, and so on.

How much material should be available for efficient operation? To work this out, we should first determine how much of any item is to be kept on the nursing division. This is done by keeping a record of the types and amounts used during a 24-hour period. This record should be kept over a two-month period. Figures collected this way may be used to determine:

1. A more correct amount or, in other words, the standard quantity for the various items maintained in the nursing unit.

2. The type and number of non-expendable items needed in circulation to maintain adequate supplies throughout the hospital.

3. The type and amount of raw materials to be stocked in the central service department.

When you have collected the figures from the survey, you are now ready to determine what your standard should be. One way of doing this is to note the maximum use of each item in each nursing area and designate that number as the standard to be maintained in that area for a 24-hour period. The next step is to total all standards from each nursing station and special areas to determine the over-all standard of supplies needed for the entire hospital for a 24-hour period. When this is completed, the following amounts of material should be kept in circulation for efficient central service operation:

1. In general, four times and preferably five times the maximum amount of linen used daily:

(a) One set in the laundry

(b) One being inspected, folded, wrapped and sterilized

(c) One in use

(d) One in storage

(e) One to compensate for transportation, breakdowns, staffing shortages, mending repairs.

2. Five times the maximum daily use of gloves:

(a) One day's supply being washed, dried, and resting overnight

(b) One being tested, powdered, wrapped, and sterilized

(c) One in quarantine

(d) One in storage, ready for use

(e) One in use.

3. Two times the maximum daily usage of items processed in central service daily and delivered to the point of use once daily. Items included would be needles, syringes, solutions, dressings, Asepto syringes, and miscellaneous items.

4. Amounts of other items, such as catheterization trays, instruments sets, intermittent bladder irrigating sets, and so forth, would

be entirely dependent upon the pickup and delivery schedule offered. Amounts for some items, such as drainage jugs, will be dependent upon frequency and time of use.

After determining the standard quantity for each nursing division, we can further check the correctness of standards simply by the use of a dispensing record.

Figure 1 illustrates the dispensing record for one item – 2-cc. syringes. The determined standard is 64. Our pattern of use indicates that over this month's period of time, we have not used 75 percent or three-fourths of our standard. If this pattern of use continued for another month I would decrease the standard by 20 percent.

This distribution form might be utilized to hold a 30-day record. The type of distribution record you use might be determined by the particular hospital policy, especially if commodity costs are alloted for operation of each unit. Depending on when or how frequently these are computed, it might be a two-week record or a 30-day record. Figure 1 also shows examples of other items dispensed in standard quantity.

Now to compute our raw supply standards. Figure 2 illustrates the ledger sheet for checking and determining the standard of raw supplies to be kept in stock. The item is listed in the item column. To the left of the item column the cabinet location and shelf number of the reserve supply room are recorded. To the right of the item column are listed the type of package dispensed and the weekly or monthly standard quantity to be maintained at that location.

The weekly number of packages possibly used or necessary to have on hand is determined by multiplying the standard number of canisters or packages used weekly (you get this from your dispensing or distribution record) by the number in each.

Combines are dispensed 1,000 to a case. If 625 are used weekly it is necessary to order one case every two weeks.

Figure 3

Determining standard for 4 x 4 gauze sponges

2/suture set	392	suture sets used per month equal	784 sponges
2/dressing set	698	dressing sets used per month	1,396 "
4/tray	2	nerve-block trays/month	8 "
6/tray	4	paracentesis trays/month	24 "
3/tray	28	spinal trays/month	84 "
6/tray	6	sternal puncture trays/month	36 "
8/tray	2	tracheotomy trays/month	16 "
6/tray	2	three-way transfusions/month	12 "
4/tray	14	cut-down trays/month	56 "
2/tray	1	local joint tray/month	2 "
		TOTAL	2,418 sponges

2418 total
.05 of total

2,418 total
+ 121 (5% extra)

120.90 for emergency or unusual increase in consumption

2,539—4 x 4 sponges as standard for use per month.

Thus, when 4 x 4 gauze sponges are purchased 3,000/case, the use is approximately one case per month.

If some items are used on treatment trays, 4 x 4's for instance, the quantities used in trays should be included to determine raw supply standard (see Figure 3).

This standard will serve as a guide so that any worker can check the raw supply standard and do the weekly ordering. Also, this standard projected over a period of several months will serve as a guide for quantity purchasing of the item. Your purchasing agent might appreciate this. Many new, improved items are constantly appearing on the market. When only adequate quantities for a limited period are purchased, i.e., three to six months, it is easy to change to a new product. There will not be in stock a large quantity of material that is not desired but must be used for the next year.

How frequently should supplies be delivered to the nursing stations? This will vary to a great extent, mainly with the size of the hospital.

Here is a recommended delivery schedule which may give you some ideas:

1. Items processed and used in quantities should be delivered and picked up one time daily. These would include needles, syringes, dressings, solutions, catheters, rubber gloves, and so forth.

2. Items processed and used frequently should be delivered and picked up approximately three times daily. These would include dressing instruments, catheterization trays, enema and drainage equipment, and so forth.

3. Other items should be delivered as required to meet the needs for patient care.

If we take the components of good personnel work habits and adequate materials, and add the catalyst of good supervision and instruction, the end result is a central service department with productivity and efficient use of personnel—plus improved, efficient patient care—the goal of all central service supervisors.

REFERENCES:

Odiorne, George S.: "Turn Poor Work Habits into Good." *Nation's Business*, November, 1958, pp. 96-99.

Doerr, Charles D.: "Good Business Is Created by Good Employee Relations," *Journal American Pharmaceutical Association* 8 (August, 1958): pp. 492-493.

"A Magnificent Achievement"

said the Lafayette, Indiana, JOURNAL AND COURIER in a Front Page Editorial:

"The Greater Lafayette community has just experienced one of its most satisfying and significant accomplishments.

"With the close of the active phase of the financial campaign . . . it is announced that $2.6 million plus has been provided in voluntary gifts and pledges toward the improvement and expansion of the two local hospitals — St. Elizabeth and Home. This sum qualifies for $1.3 million in federal aid, under the Hill-Burton act, making a grand total of over $4 million available. And the fund is still growing!

"Nothing even faintly approaching this achievement, in a capital fund campaign, has ever taken place here. As remarked in these columns 14 months ago, this was the most ambitious and pretentious fund-raising venture in the community's entire history.

"The result of the campaign is most exciting and thrilling. There were doubts that it could be done. But it was.

"The campaign was a team effort, spectacularly organized and promoted. Karl H. Kettlehut, general chairman, and his campaign organization gave highly dedicated service. More than 25,000 individual donors responded generously with their hearts and substance. All who took part in the magnificent community effort deserve public thanks and the everlasting gratitude of present and future citizens."

— Excerpts from Editorial, June 30, 1960

COMMUNITY:	**Lafayette, Indiana**
POPULATION (Est. 1960):	**55,000**
HOSPITALS:	**St. Elizabeth Hospital** **Lafayette Home Hospital** a united HEALTH campaign
CAMPAIGN GOAL:	**$2,000,000**
AMOUNT RAISED:	**$2,600,000**

The skilled professional direction of Tamblyn and Brown, Inc. was recognized as an important factor in enabling the civic-minded leaders and other volunteer workers of the Lafayette campaign to obtain more than 25,000 gifts from individuals, business, and industry in a low-cost campaign especially adapted to prevailing conditions.

Information as to how our 40 years of successful experience in fund raising can help your hospital in capital financing will be given gladly without cost or obligation.

Tamblyn and Brown, Inc.

EMPIRE STATE BUILDING NEW YORK 1, NEW YORK

CHARTER MEMBER: AMERICAN ASSOCIATION OF FUND-RAISING COUNSEL

Personally Speaking

His Majesty Bhumibol Adulyadej, king of Thailand, expresses his thanks for a silver reproduction of his birth record, presented to him at a garden reception at his birthplace, Mount Auburn Hospital, Cambridge, Mass. In the inset at lower right is Stewart Whittemore, M.D., who attended at the king's birth. Standing with the young monarch are (l. to r.) Daniel Needham, Jr., chairman of the hospital board; John Kowal, assistant administrator; and Robert J. Robertson, administrative resident.

Paul Frank Avard – has been named director, St. Luke's Convalescent Hospital, Greenwich, Conn. He recently completed his administrative residency at the Somerset (N. J.) Hospital.

Sanford K. Bronstein – has been appointed administrator, Cedars of Lebanon Hospital, Miami, Fla. The 108-bed hospital is at present under construction.

Mr. Bronstein was formerly associate executive director, Jackson Memorial Hospital, Miami.

Lee Ben Clarke – is the new administrator, Humphreys Memorial Hospital, Fernandina Beach, Fla. He was formerly administrative assistant, City-County Hospital, LaGrange, Ga.

Richard L. Durbin—has been named director, out-patient services, Presbyterian-St. Luke's Hospital, Chicago. He formerly served as associate administrator, City of Memphis (Tenn.) Hospitals.

Richard Holladay – has been named administrator, Bay Memorial Hospital, Panama City, Fla. He was formerly assistant administrator, Baptist Hospital, Pensacola.

A. H. Jeffers – is the new administrator, Lawrence County Hospital, Lawrenceburg, Tenn., succeeding **John Maloney,** who has been named administrator, Morristown-Hamblen Hospital. Mr. Jeffers was formerly administrator, Bacon County Hospital, Alma, Ga.

Clifford R. Rostomily – has been selected for the newly-created post of director of administrative services, Children's Hospital, Columbus, Ohio. He was formerly administrator, Lawrence County General Hospital, Ironton.

At the Columbus hospital, **Jacqueline Kruman, R.N.,** will become director of nursing administration Oct. 1, succeeding Elgie Wallinger, who has retired.

Katherine M. Schenk – has been appointed director of nursing education, Mary Hitchcock Memorial Hospital School of Nursing. She assumes the post in mid-September, succeeding **Mary Louise Fernald,** who has resigned.

Sister Anthony Marie – has been appointed administrator, St. Vincent's Hospital, New York City, succeeding **Mother Loretto Bernard.** Sister Anthony Marie was formerly assistant administrator of the hospital.

Sister Mary Rose – is the new administrator, DePaul Hospital, St. Louis, Mo. She was formerly administrator, Mary's Help Hospital, San Francisco, Calif.

George Henry Stone – is new administrator, Children's Orthopedic Hospital, Seattle, Wash. He was formerly administrator, John D. Archbold Memorial Hospital, Thomasville, Ga.

James R. Stricker—is the new assistant administrator, City Memorial Hospital, Winston-Salem, N. C. He was formerly at Lake County Memorial Hospital, Painesville, Ohio.

(Continued on next page)

Maj. Edward M. Strobel, MSC – has been appointed chief, Technical Liaison Office, Army Surgeon General's Office. Maj. Strobel was formerly hospital inspector general, Madigan General Hospital, Tacoma, Wash.

James E. C. Walker, M.D. – has been named assistant director, outpatient and emergency department, Peter Bent Brigham Hospital, Boston. He was formerly senior resident physician.

Fred C. Washburn – has been appointed administrative assistant, Aultman Hospital, Canton, Ohio. He was formerly in administrative residency at the Charles S. Wilson Memorial Hospital, Johnson City, N. Y.

Newly appointed administrative resident at Aultman Hospital is **John H. Bergman,** a graduate student in the school of hospital administration, University of Michigan.

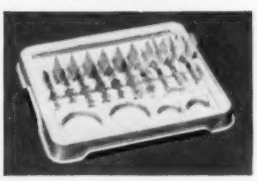
BUNN MEDICATION and SYRINGE TRAYS

Prevent Mistakes - Save Time

New types of trays accommodate all sizes and shapes of medication cups, syringes and thermometers. Lock-in slots hold medication cards securely. BUNN MEDICATION TRAYS may be used with the Bunn Medication Card Technique or any other system.

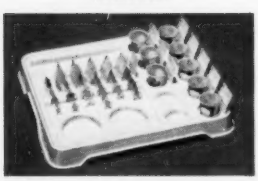
MEDICATIONS

USE THEM PIGGY-BACK — CARRY TWO WITH ONE HAND



SYRINGES

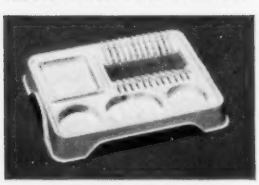
Bunn Medication Trays are specifically designed to fit one on top of the other. A nurse is able to deliver medications to patients carrying two trays in one hand . . . a great time saver.



MEDICATIONS AND SYRINGES

ECONOMICAL - EASY TO CLEAN LIGHT WEIGHT-STACK COMPACTLY

Made of high-impact styrene, Bunn Medication Trays are virtually unbreakable. They clean quickly and thoroughly by hand or in an automatic dishwasher.



THERMOMETERS

MEDICATION CARDS AND WALL RACK

Bunn Medication and Syringe Trays and the Bunn Card Rack, used with the Medication Cards, combine into a complete system which minimizes medication errors. Cards are filed in the rack according to the first hour checked for medication. The card then accompanies the medication on the tray. Each card shows a 24-hour medication schedule for each patient.

Write for Complete Information.

Manufacturers and Distributors of Specialized Hospital Equipment

JOHN BUNN CORPORATION

163 ASHLAND AVE. BUFFALO 22, N. Y.

Alfred S. Zukon – has been appointed superintendent, Elmer (N.J.) Community Hospital. He was formerly assistant administrator, Jamaica (N.Y.) Hospital, where he will be succeeded by **John F. Fletcher.**

New Officers

Mrs. Susie T. McKeehan, CRL–St. Paul's Hospital, Dallas, has been elected president, Texas Association of Medical Record Librarians. Other officers are **Mrs. Minette Howe Rea, RRL,** Garland Clinic and Hospital, Garland, vice-president; **Mrs. Opal Adams Herron, RRL,** St. Joseph's Hospital, Houston, president-elect; **Shirley M. Robinson, RRL,** St. Mary's Infirmary, Galveston, secretary; and **Laura M. Koetting, RRL,** Breckenridge Hospital, Austin, treasurer.

New officers of the Hospital Purchasing Agents Association of Texas are **Mrs. Othelia Boone,** Wichita General Hospital, Wichita Falls, president; **John R. Willis,** Parkland Memorial Hospital, Dallas, vice-president; **Bill Coltharp,** Hermann Hospital, Houston, president-elect; **W. E. Riley,** San Jacinto Memorial Hospital, Baytown, secretary-treasurer. **Edward Glaze,** Memorial Hospital, Corpus Christi, was named general chairman of committees.

New president of the Texas Conference of Catholic Hospitals is **Sister Peter Gerard,** St. Joseph School of Nursing, Fort Worth.

Deaths

Homer E. Alberti – 65, died July 30. He had been administrator, Winchester (Va.) Memorial Hospital for the past 15 years.

Mr. Alberti was a past-president of the Virginia Hospital Association, and at the time of his death was a member of AHA, a Fellow of ACHA, and a lecturer, faculty of the School for Hospital Administrators, Medical College of Virginia.

Morris Ant, M.D. – 65, died June 25 at New Haven, Conn. Dr. Ant was a specialist in internal medicine and metabolic diseases.

For further information see postcard opposite page 116.

Progress Report on Autoclave Wrapping

...based on questions asked about DennisonWraps by OR Supervisors at the 1960 AORN Convention.

Q. *What outstanding reason do hospitals give for replacing muslin and other autoclave wrappers with DennisonWraps?*

A. Many hospital authorities are convinced that DennisonWraps are safer to use than other wrapping materials. Large hospitals are also attracted by the lower cost per use and the elimination of laundry bottlenecks. Smaller hospitals list space savings and faster drying as additional factors.

Q. *What evidence is there that DennisonWraps satisfy all sterility requirements?*

A. Published reports of clinical tests, available on request, establish that:

1. For standard wrapping procedures DennisonWraps are significantly superior to muslin in terms of time required to reach a given temperature.
2. DennisonWraps will maintain sterile conditions at 35°C, 24°C and 4°C for varying lengths of time up to 6 weeks.
3. Bacteriological tests performed on DennisonWraps which had been used 10 times produced negative results consistently.

Since 1957, numerous hospitals have confirmed the accuracy of these statements.

Q. *What must be done to assure the return of DennisonWraps to Central Service for reuse?*

A. Nothing! All DennisonWraps—pre-cut sheets, tubing, glove envelopes and cases—carry the hygienic imprint: "Reusable DennisonWraps . . . return to Central Service." This constant reminder guarantees maximum reuse and lowest cost per use.

Q. *What is the basis of the claim that DennisonWraps have a lower cost per use than muslin?*

A. A comprehensive hospital study conducted by Mrs. Jean E. Christie, R.N., as reported in HOSPITAL TOPICS, March-April, 1957, established these facts:

Size of Wrap	Muslin Cost per use @ 50 uses	DennisonWraps Cost per use @ 6 uses	DennisonWraps Cost per use @ 1 use
15″ x 15″	.02251	.01027	.02189
30″ x 30″	.05335	.01757	.05740
40″ x 40″	—	.02846	.09049
45″ x 45″	.09697	—	—

Q. *Does the use of DennisonWraps involve any change in wrapping techniques?*

A. No! Because DennisonWraps are made of double-creped paper with two-way stretch, they have folding and shape-conforming properties similar to muslin. Moreover, since they lack the bulk and floppiness of muslin, hospitals report that it is much easier to train new personnel to wrap with DennisonWraps.

Q. *What's the first step in making the transition to DennisonWraps?*

A. Write for a free hospital evaluation kit. It contains test quantities of DennisonWraps in precut sheets, glove wicks, envelopes and cases, 3″ tubing, *plus* three clinical reports which prove that DennisonWraps will increase the safety, efficiency and economy of your autoclaving operations. Address your request to Dennison Manufacturing Co., Dept. J-171, Framingham, Mass.

DennisonWraps

the original
reusable Double-creped Paper
for superior autoclaving
at lower cost

For further information see postcard opposite page 116.

"POWDETTE"®
GLOVE POWDER PACKETS
U.S.P.
IN COUNTER-TOP PACKAGE.

Here's the convenient "POWDETTE" counter-top box, good-looking enough to leave in plain sight. Help yourself to one or a handful of packets of this soft, smooth, fluffy starch powder that is safe for surgical use — laboratory tested. Each sealed packet contains **more than** 1½ grams of powder that has been specially formulated to lubricate surgical gloves. Starch base, absorbable.

Compare the price. Ask your supply dealer to order a trial box so that you can compare the quality. Samples upon request. The counter-top box of

1728 PACKETS $18.50*

If your dealer cannot supply, order direct, giving your dealer's name.

DUXE PRODUCTS
MEDICAL-DENTAL SPECIALTIES

P. O. BOX 1192 **CINCINNATI 1, OHIO**

*** Suggested Hospital Price.** **List price $23.05**

SAVE PRECIOUS TIME!...use

CLYSEROL

THE NEW, ORIGINAL 5-MINUTE ENEMA SOLUTION in the disposable plastic container with the self-lubricating tip.

Clyserol, now the standard enema in thousands of hospitals and clinics, has proved safer and more efficient than SS enemas . . . easier to administer . . . more acceptable to patients of all ages . . . and such a time-saver for personnel that its small purchase price is quickly repaid.

Available through your local surgical supply dealer.

Write Today For Information and

FREE SAMPLES!...

CLYSEROL LABORATORIES, INC.

1533 WEST RENO, OKLAHOMA CITY, OKLAHOMA

(Continued from page 70)

oped. There is no excessive overweight.

6. They have more resistance to the common illnesses of early infancy.

"With 34 years experience in feeding, I find that milk (including various supplements) is not the perfect food to be used alone for a long period," Dr. Roche commented. "Physicians stress a balanced diet for children. Why not give it to them from the start? They can digest food as well as their older brothers and sisters."

More than 20 years ago Dr. Roche started using a feeding schedule of five feedings daily. Over the years he observed that many infants would automatically place themselves on three or four feedings daily if they were not awakened. His observations led him to adopt the six-hour feeding schedule about seven years ago.

Dr. Roche gives a printed schedule to his mothers which includes the following list of suggestions on when to add certain foods to the infant's diet:

3-4 days—cereal (6 a.m., 6 p.m.)

10 days—strained vegetables—peas, green beans, carrots or mixed vegetables

14 days—vitamin concentrate—2 drops daily; increase 1 drop monthly until 5 drops are given each day

17 days — strained fruit (6 p.m.) — applesauce, peaches, or pears (decrease cereal feeding to one daily)

3 weeks—add orange juice and sterile water—equal parts—up to 2 oz. each. May be given midmorning or midafternoon

4 weeks—add strained meat

5 weeks—add custards and puddings

6 weeks—add soups—meat and vegetable

7 weeks—add mashed banana—very ripe or canned

8 weeks—add hard-boiled egg yolk.

Dr. Roche tells his patients that sterile water may be given freely between feedings. He makes these additional suggestions:

—If the baby is not satisfied for the full six hours between feedings, he probably is not receiving enough solid food.

—If constipation occurs, add strained prunes to cereal.

—Formula should be used for the cereal and to make soups and vegetables thinner. If the baby is breast-fed, homogenized milk should be used.

—Occasionally orange juice will cause colic. If it does, it should be discontinued until the infant is older.

—If the formula does not satisfy the infant at the night feeding, solid food should be given.

—The infant should be burped after solid food is given and again after formula is given.

REFERENCES

1. Sackett, Walter W., Jr.: *A Manual on Baby Feeding.*
2. Sackett, Walter W., Jr., and Sheppard, Ben J.: "Further Observations on a New Concept of Baby Feeding." *The Journal of the Florida Medical Association* 39: 21-25 (July, 1952).
3. Sackett, Walter W., Jr.: "Results of Three Years Experience with a New Concept of Baby Feeding." Southern Medical Journal 46: 358-363 (April, 1953).
4. Sackett, Walter W., Jr.: "A New Approach to Infant Feeding. *Southern Medical Journal* 50: 340-342 (March, 1957).

Carolina
MULTI-LAYER
COMBINATION PADS AND ROLLS

Absorb More . . . Hold More . . . Last Longer

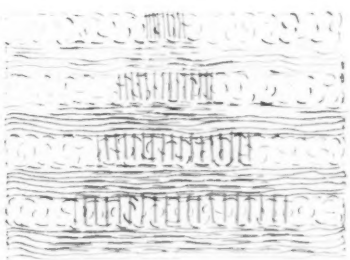
Carolina combines the two most efficient absorptive materials — cotton and cellulose — into a pad guaranteed to provide greater comfort for the patient, greater economy for the hospital.

Alternating several layers of cotton and cellulose makes a more effective pad with the best features of both products.

The bottom layer is of *non-absorbent* cotton for further diffusion of drainage. It is practically leak-proof — helps prevent staining of bedding and garments, makes each pad last longer in use.

This schematic drawing shows the action of Carolab Combination Pads—
cotton has a *retentive* absorption
cellulose has a *capillary* absorption

The combined action of "holding" and "spreading" diffuses the drainage throughout the pad, provides—
maximum absorption
maximum time in use



COMPLETE RANGE OF SIZES. WRITE FOR SAMPLES, PRICES, INFORMATION.

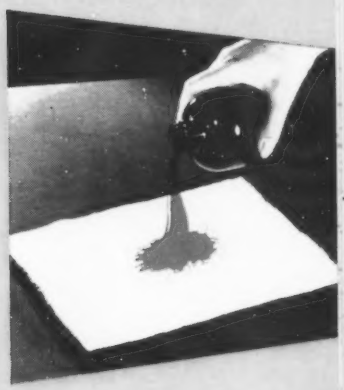
ALL-ABSORBENT PADS — same as above, alternating layers of cotton and cellulose, but without non-absorbent cotton backing, are also available in all sizes.

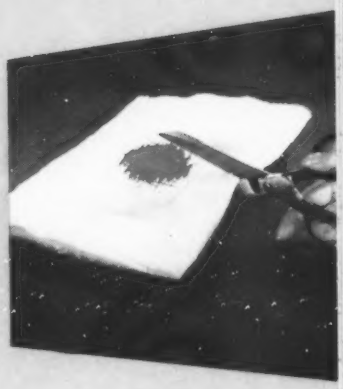
CAROLINA ABSORBENT COTTON CO.
(DIVISION OF BARNHARDT MFG. CO., INC.)
CHARLOTTE 1, NORTH CAROLINA

MANUFACTURED WHERE GROWN

Carolab Hospital Supplies

Try This Test!





You Can See and Feel the Difference!

See the smooth finish of these Carolab cotton balls . . . feel the firmness, too. This is virgin long-staple cotton, carefully spun so that there are no nibs, no loose wispy ends. Carolab cotton balls are soft, yet with proper density for greater absorbency.

There is a complete range of sizes—five to meet every need in the hospital . . . from nursery to accident ward, from pharmacy to blood bank and laboratories.

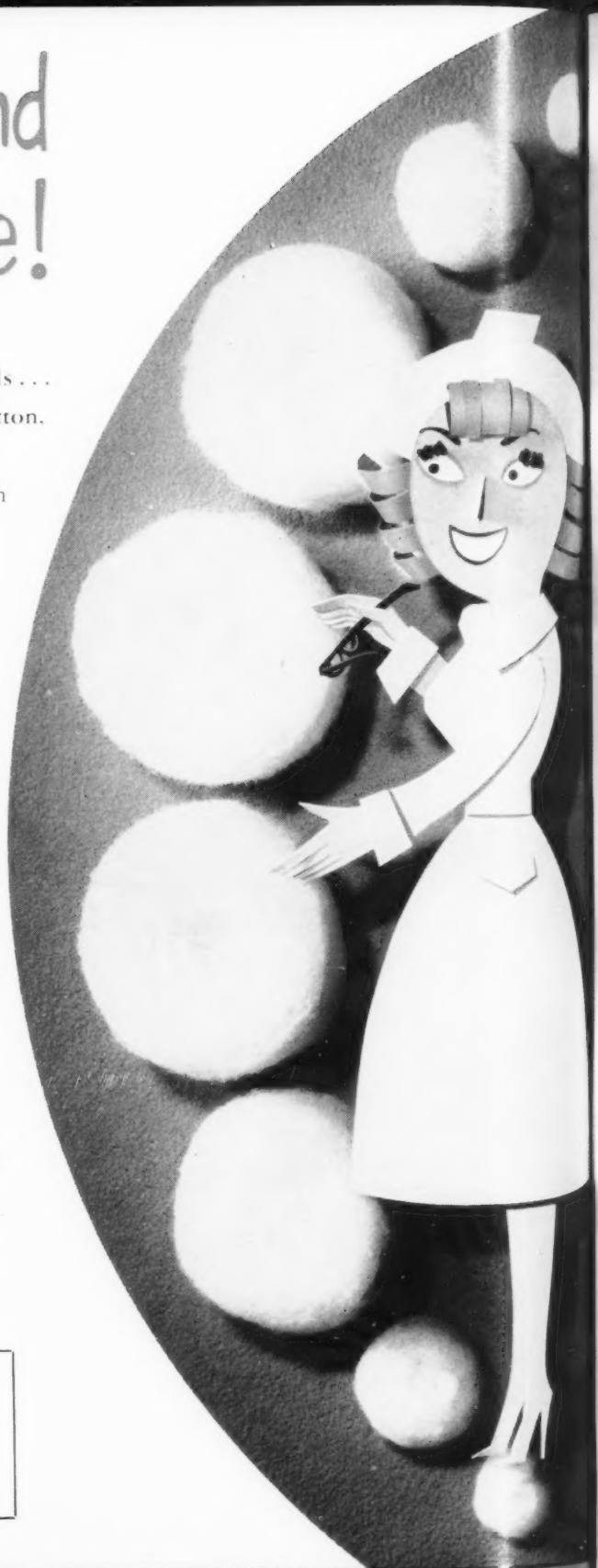
Carolab cotton balls are economical, too. They replace sponges in many hospital procedures to provide improved technic as well as lower cost. You will find Carolab is truly a better ball at a lower price.

Manufactured Where Grown

super	2000 per case	
special	2000	special is same size as large
large	2000, 4000	but is almost twice as dense
medium	4000, 8000	
small	8000	

rayon balls also available in the four larger sizes; same packing and price.

On request, a large sample case of the complete line of Carolab surgical dressings will be delivered for inspection by OR, OB and CRS supervisors, purchasing agent or business manager, and other interested hospital personnel.



CAROLINA ABSORBENT COTTON CO
(Division of Barnhardt Mfg. Co., Inc.)
P.O. 2176 Charlotte 1, North Carolina

HOSPITAL Topics

Book Corner

A CHECK LIST FOR NURSING SERVICE POLICY MANUALS, *by Sister Jean Marie Braun, S.C.S.C. St. Louis, Mo., Catholic Hospital Association, 1960. 3 copies, $1.00. 13 pp.*

The material in this booklet was abstracted from an essay presented to St. Louis University as part of the requirements for a master's degree in hospital administration.

After a comprehensive introduction covering definition of terms, need, formulation, enforcement, and revision of policies, a complete check list is presented. The list is intended as an outline in the preparation of policies and manuals, and for the constant revision of policy.

The general nursing service section covers accidents, communicable diseases, legal documents, emergencies, fire regulations, information, and a selection of other items.

The list headings, in addition to general nursing service, include spiritual care, pediatrics, obstetrics, operating room, emergency room, and central supply.

FALLOUT, *edited by John M. Fowler. New York, Basic Books, Inc., 1960. $5.50. 235 pp.*

Subtitled "A Study of Superbombs, Strontium 90 and Survival," this book is made up of a series of individual writings by noted experts in the various facets of atom-splitting.

Although necessarily dealing with an extremely complex, technical subject, the book's chapters are written in an easy-to-understand manner, and what could have been a complicated textbook is instead a readable, straightforward account of the dangers of radioactivity.

The eleven chapters deal with the superbomb and its products, biological and genetic effects of radiation, the rising level of fallout, civil defense, nuclear war and national survival.

Contributors include James F. Crow, president of the Genetics Society of America, Ralph E. Lapp, executive director of Atomic Energy for Research and Development Board, and Lester Machta, chief, Special Projects Section, United States Weather Bureau. Foreword by Adlai E. Stevenson.

SO YOU'RE GOING TO THE HOSPITAL, *by Leonard Berlow, M.H.A. and Vincent J. Bagli, M.D. Illustrated by Wesley A. Roads, M.D. Washington, D.C., The Association of Military Surgeons of the United States, 1960. $1.00. 194 pp.*

The hospital experience is usually viewed with apprehension and uncertainty by the patient and his family. This book was written in an effort to create better understanding between the hospital and its patients by supplying the patient with concrete information about the complexities of hospitalization.

Hospitals and medical and surgical treatments are described in a non-technical manner, and the book is generously, often humorously, illustrated with pen sketches.

OFFICE DIAGNOSIS, *by Paul Williamson, M.D. Illustrated by Ann Williamson. W. B. Saunders Co., 1960. $12.50. 470 pp.*

According to the author, this book is "not a compendium of diagnostic technics and maneuvers." His idea was to stimulate thinking about diagnosis, which he terms a personalized discipline.

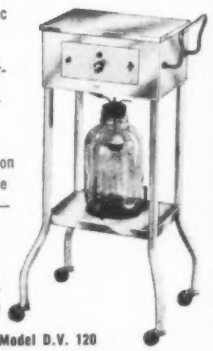
The book contains diagnosis procedures which can be performed in the usual physician's office, using some laboratory, x-ray, and ECG methods. Diagnoses requiring complicated apparatus are not included.

The author's wish in writing this excellent book was to see it on the physician's bedside table rather than gathering dust on the office shelf. In making the material not only factual, but wholly readable, he has, in his own words, "occasionally taken a tongue-in-cheek swipe at some sacrosact premise of medicine."

Certainly worthy of special mention are the many drawings and charts by Ann Williamson illustrating the procedures. The large page format, easy-to-read typography, and generally fine mechanical quality of the book make it a handsome volume.

DUO-VAC
THE DUAL PURPOSE INTERMITTENT AND CONTINUOUS
Drainage Pump

- Mild — Automatic
- Dependable — Economical
- 90-250 M.M. Mercury
- Displacement 4 Liters P.M.
- Quiet Operation
- Controlled Suction
- Compact — Mobile
- 110 V. 60 Cycles — A.C. Only
- D.V. 120 White Enamel Finish
- D.V. 121 Stainless Steel Cabinet and Shelf, Chrome Stand.



Model D.V. 120
Prices, Etc., Write Dept. D.V.T.

dak
D. A. KADAN CO., Inc.
YONKERS, N. Y.

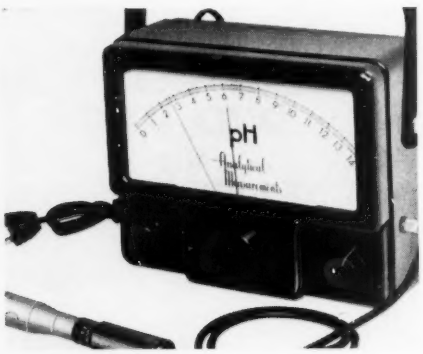
CLASSIFIED

NURSE ANESTHETIST: Male or female. Need be qualified to administer all types anesthesia. Base salary $650 per month, on call basis. Liberal benefits. 86-bed hospital with 50-bed new addition. 11 doctors comprise medical staff with average 3 majors per day. Applicants must be available by Sept. 1, 1960. Apply: James A. Hall, administrator, Victory Memorial Hospital, 5th Avenue, Stanley, Wisconsin.

NURSE ANESTHETIST: 30-bed general hospital 65 miles north of Mobile, Ala., on highway 43. Starting salary $7,200 plus commission for weekend work. Liberal personnel policies. Apply to Mr. John C. Neal, administrator, Jackson Hospital, Jackson, Ala., or telephone Chestnut 6-2407 collect.

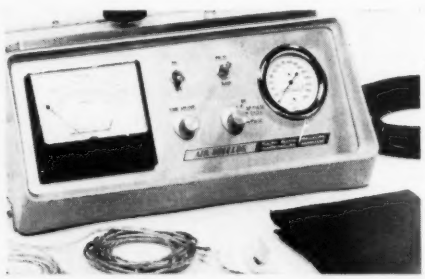
BUYER'S GUIDE

For further information on any of the products, please check the Buyer's Guide number on the reply card opposite page 116.



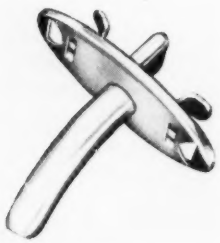
200. pH meter

New concept in pH instrumentation, Model 700 has oversize scale for quick, easy reading; compact, lightweight housing for one-hand portability. Features single operating control and has a high output electronically modulated amplifier, with printed circuitry and sensitive meter elimination. Originally designed polyethylene electrode probe unit permits user to "bring the meter to the sample, not the sample to the meter." Analytical Measurements, Inc., 585 Main St., Chatham, N. J.



201. Cardiac monitors

Three new cardiac monitors are available: pulse, temperature and blood pressure; pulse and temperature; and explosion-proof pulse and blood pressure. Shown is the pulse, temperature and blood pressure model which integrates the pulse rate for direct, continuous reading on a meter. Temperature may be monitored at any time by turning meter switch from pulse rate to temperature. At four-minute intervals, systolic blood pressure is automatically monitored. Air-Shields, Inc., Hatboro, Pa.



202. Tube

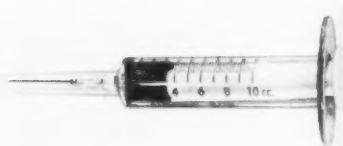
Designed for infants and children, trachea tube's shorter length and sharper angle make it anatomically correct for this age group. Four sizes: 00, 0, 1 and 2; supplied with obdurators. Chart, available on request, gives all lengths and openings, simplifies ordering. Unconditionally guaranteed. Dittmar & Penn Corp., Philadelphia, Pa.

203. Sprayer

New pistol type sprayer has plastic container which cannot break or dent, corrode or leak; is inert to all acids and alkalis. Light, compact, the container permits user to see how much liquid is inside. Features improved hand grip control. Idico Products Co., 18 West 125th St., New York 27, N. Y.

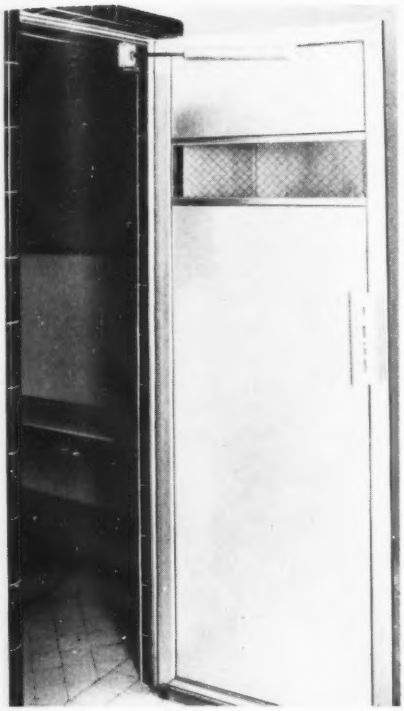
204. Refrigerated centrifuge

New vacuum-type refrigerated centrifuge is said to be the first ever made to spin a capacity of 1500 ml. (6 x 250 ml.) at 60,000 x G, and 3,300 ml. (6 x 550) at 33,000 x G. Also interchangeably accommodates and spins smaller rotors with 400 ml. (8 x 50 ml.) and 360 ml. (24 x 15 ml.) at forces up to 51,000 x G. Refrigeration design permits operation of rotor with temperatures as low as −10°C during extended high speed runs, or at −20°C during shorter runs or at lesser speeds. When operating under a vacuum, material temperatures can be maintained within 1°C for temperatures as low as −10°C. All controls in easy reach and view. Lourdes Instrument Corp., 53rd St. & First Ave., Brooklyn 32, N. Y.



205. Disposable syringe

New disposable syringes are available in sizes 1cc TB, 1cc Insulin, 2cc, 5cc, 10cc and 20cc's. Individually packed in sterile containers, syringes feature securely fastened, but easily removable, needle guards and a positive action safety sealed plunger unit. Clear plastic barrel construction with hot stamped markings for easy reading. Also available without needles. Hospital Products Corp., 87 N. Sixth St., Columbus, O.



206. Hot/cold door

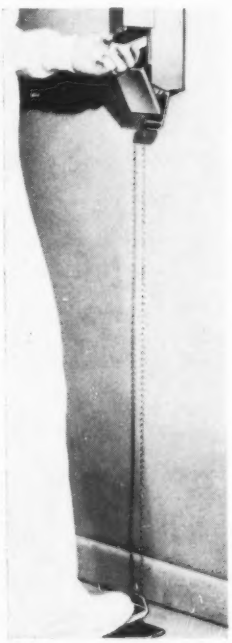
Designed for temperature and humidity control, new door is constructed of heavy-duty aluminum with clear wire glass opening or full-length wire glass. Channel frame is of heavy-gauge store front aluminum and ⅛" aluminum sheeting set in neoprene channel. Non-corrosive, impervious to moisture; completely insulated and weatherproofed around jambs. Designed to fit any door opening. American Shower Door Co., Inc., 936 N. Cahuenga Blvd., Hollywood 38, Calif.

207. Sterilization paper

Pro-Tex-Wrap, new crepe, embossed, wet-strength paper for sterilization, comes in 9" diameter rolls, 12, 24, and 36 inches wide, for mounting on a paper cutter. Any size sheet can be quickly cut off as needed to wrap instruments, syringes, pans, and other items. Fast and economical to use; conserves storage space. Pro-Tex-Mor Medical Division of Central States Paper and Bag Co., St. Louis, Mo.

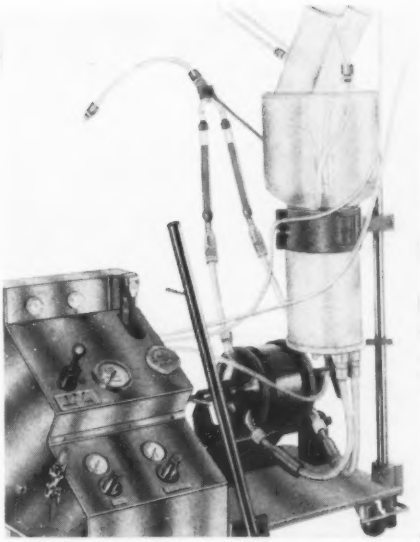
208. Incubator

Plasma fractions, vaccines, liver extract, insulin and heat or light sensitive medications are among items which may be stored or conditioned in new model low temperature incubator. In addition to 12% increase in working space, unit offers temperature range of 5°C to 50°C, built-in heaters and cooling system, forced air circulation, adjustable shelves, dial thermometer, and external controls. Precision Scientific Co., 3737 W. Cortland St., Chicago 47, Ill.



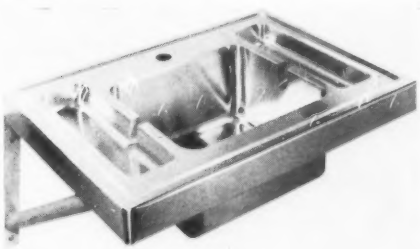
209. Brush

Slight pressure of new pedal accessory delivers a sterile brush for scrub-up. Of stainless steel to match dispenser, accessory is easily attached to present arm-operated units to convert to foot operation. Equipped with a spring loaded hinge; chain and base mounted on 3/16" rubber pad. American Hospital Supply Corp., 2020 Ridge Ave., Evanston, Ill.



210. Pump oxygenator

New type of pump oxygenator for thoracic and cardiovascular surgery permits complete bypass of the blood from the heart and lungs, allowing procedures by direct vision. Need for donor blood for priming purposes (usually from three to 24 pints of fresh blood in conventional models) is eliminated because the unit is primed with one liter of physiologic saline solution, which remains in the Pulspirator during the operation as a stratum above the blood. Economical, simple, and easy to operate. No electricity required, as the unit operates by oxygen from line pressure or cylinder and may be converted instantly to manual operation. Since its introduction, the Pulspirator has been successfully used in more than 50 open-heart procedures. Descriptive brochure with illustrations and schematic drawings available on request. The Foregger Co., Inc., Roslyn Heights, N. Y.



211. Instrument lavatory

New line of surgical instrument lavatories includes the wall-mounted model shown, which is designed for washing and on-the-spot draining of instruments prior to sterilization. Overall lavatory length is 28", width is 20". Made of nickel-bearing stainless steel, model has a draining compartment on either side of the bowl for maximum convenience and efficiency. Just Manufacturing Co., 9233 King St., Franklin Park, Ill.

For further information see postcard opposite page 116.

606

Take the needle out of the patient...

...and ensure optimum patient comfort during intravenous infusion, by use of the Bardic® Deseret Intracath® This ingenious unit (sterile and ready for use) makes the venipuncture and places a soft, pliant catheter in the vein ... the needle is then withdrawn and becomes an adapter for any I.V. set • No rigid needle remains in the vein; no armboard is needed • Most venous cutdowns are eliminated; scrubbing or gloving is not required • As the Intracath may be left indwelling for several administrations, there is less trauma, minimized reaction, and the need for repeated venipunctures is reduced. The Intracath is convenient and time-saving for the hospital; safer, more comfortable for the patient.

C. R. BARD, INC. • SUMMIT, N. J.

INTEGRITY QUALITY BARD SERVICE SINCE 1907

The Bardic® Deseret Intracath® is available through your Hospital/Surgical Supply Dealer in 6" or 12" catheter lengths, with 14, 17 or 19 gauge needles. For complete information and detailed Procedure for Introduction, request Bard brochure CS-6

212. Caution stand

Danger of costly wet floor accidents can be reduced to minimum with highly-visible, two-sided signs of tempered Masonite riveted to galvanized, non-rusting steel frames. Non-marking rubber feet preventing slipping. Vivid colors on both sides warn pedestrians away from slippery floors, isolate freshly cleaned areas for drying without contamination. Self-folding stands are fully assembled, packaged in sets of five, with metal wall bracket for off-floor storage. Walton-March, 1592 Deerfield Rd., Highland Park, Ill.

213. Portable aspirator

New Frye unit, designed to provide emergency suction in ambulances, rescue units, and autos, features suction gauge and regulating valve; 32-oz. suction bottle; motor unit requiring no lubrication; special plug with 14' cord which fits any standard automobile cigarette lighter; simple filtering system utilizing standard 1" gauze bandage. Develops 15 inches of negative pressure. Complete in case with rubber tubing, Sklar coupling, lighter plug, Yankauer suction tube. J. Sklar Mfg. Co., Long Island City 4, N. Y.

214. Diagnostic aid

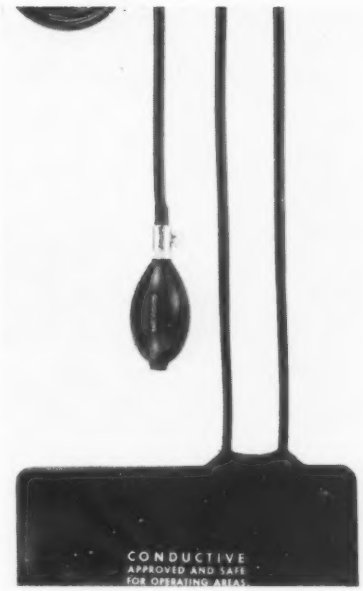
Hemoccult, for detection of occult blood in feces and urine, is simple, one-minute diagnostic test containing all the necessary materials in one compact, portable form. Features special electrophoresis filter paper impregnated with guaiac gum, which remains stable indefinitely when protected from direct sunlight, ultra-violet light or strong heat. Paper is provided as a 100" strip in plastic dispenser. Developer solution is provided to render rapid definite results. Each kit will perform 100 tests. Schieffelin & Co., 30 Cooper Square, New York, N. Y.

215. Hydro-hotpak

New model H-1 Hydro-HotPak cabinet is economical, fully automatic, portable water heating unit, combining such exclusive features as handy switch, extra-large capacity, three-conductor cord, non-drip lid. Weighs 19 pounds complete with five standard size Hydro-HotPaks (maintained ready for immediate moist heat applications), and one standard-size Hydro-ColdPak. Both the HotPaks and ColdPaks come in standard-size, 10" x 12"; and in half-size, 5" x 12". Logan, Inc., 4966 Eagle Rock Blvd., Los Angeles 41, Calif.

216. Audiometric room

New room, for testing persons' hearing, can be assembled in a few hours without special tools. Shipped in 24 to 36 components, depending on the model, as against the average 75 parts. Largest model is 96 inches wide, 96 inches deep and 93 inches high—large enough to accommodate three subjects at one time. Test enclosures guarantee a noise reduction of up to 55 decibels, depending on the octave band, assuring adequate testing conditions even when the room is installed in a fairly noisy area. Koppers Co., Inc., 200 Scott St., Baltimore, Md.



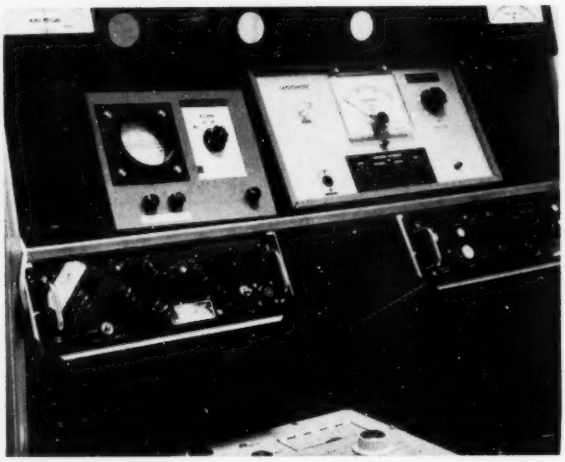
217. Blood pressure cuff

New Baumanometer Conductive V-Lok Inflation System is made of finely woven fabric coated on both surfaces with conductive neoprene; utilizes new Velcro closure. Bulb, bag and tubing are all seamless, dipped conductive Latex; includes extra length (four-foot) conductive Latex tubing and air-flo control valve. Can be used with any blood pressure instrument; fully tested and approved safe. W. A. Baum Co., Copiague, N. Y.

218. Phone message book

Sturdy, plastic spiral binder with imitation leather cover contains 400 perforated message blanks. Carbon copies of messages are recorded on unperforated full sheet duplicates which remain filed in binder as permanent record of all incoming calls. Four 7¼" x 2 11/16" forms to a page; ample supply of carbon paper. Imprinting and numbering on request. Cromwell Business Forms, Albany, N. Y.

For further information see postcard opposite page 116.

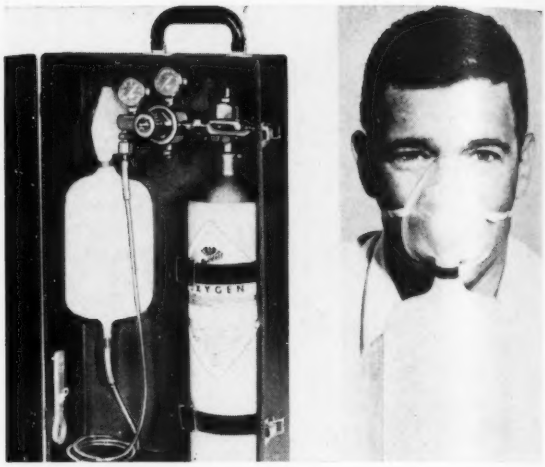


219. Cardiometer,® monitor oscilloscope

A cardiac monitor, an artificial pacemaker, and a monitor oscilloscope are shown on cardiac cart. Cardiometer® incorporates in one unit device to give instant detection of patient's difficulty, and pacemaker that gives immediate external stimulation. Monitoring portion has automatic alarm, audio-visual signal of the ventricular contraction, and constant heart rate indication. Pacemaker portion has automatic or manual setting. The monitor oscilloscope has either triggered or continuous sweep and operates with or without cardiometer; also three speeds with which to observe the QRS complex, plus carefully measured scale that corresponds to the electrocardiograph and allows even further interpretation. Cardiometer also has connection for an electrocardiograph. Emphasis is on ease of operation as indicated by the fact that these instruments operate from three small-sized, easily placed electrodes. No strap or limb electrodes are needed. The company also manufactures a cardiac cart (shown in the June Buyer's Guide) and a defibrillator. Physio-Control Corp., 4719 Brooklyn Ave., Seattle 5, Wash.

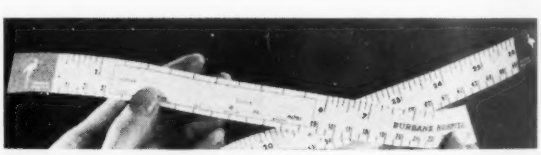
220. Thermo-Fax recording paper

Calcop, new recording paper for use on Thermo-Fax equipment, has opaque white surface which eliminates light reflection and glare. Does not curl when run through machine; not translucent, each sheet is clearly readable even when stapled together. Paper is flexible, doesn't crack when folded or creased. Not affected by sunlight, prolonged filing. Calor Copy Corp., 387 Park Ave., S., New York, N. Y.



221. Portable oxygen unit

New, low-cost portable oxygen unit contains 360 liters of oxygen, enough for approximately 40 minutes' use. Emergency oxygen can be administered almost instantaneously simply by opening the cylinder valve, turning the flow adjustment knob, and placing mask on the patient's face. Cylinder is standard type, easily refilled. Highly accurate; easily regulated to allow proper amounts of oxygen. Useful in cases involving heart attacks, shock, fainting spells, or nullifying the effects of anesthetics. Complete unit, including apparatus, filled oxygen cylinder, and luggage-type case is 21½" x 12½" x 5". Medical Division, Burdett Oxygen Co., 3300 Lakeside Ave., Cleveland 14, O.



222. Measuring tape

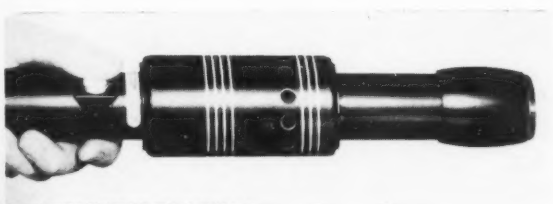
Disposable measuring tape, Baby Tape is made of moisture-resistant paper and may be autoclaved. Marked in centimeters and inches, the 26" tape is long enough to measure average-sized infants for several months. Imprinted with hospital name, city, and state without extra charge; space provided for recording birth information and growth. Tape makes attractive take-home gift for mothers. Hollister, Inc., 833 N. Orleans St., Chicago 10, Ill.

223. Linen inspection table

Inspection of hospital linen is easier and more positive with new inspection table, which is illuminated from beneath by fluorescent lighting and detects holes and flaws in operating room packs, sterile and non-sterile linen. Table measures 24" x 60" x 31". Illuminated section measures 8" x 50", with frosted plexi-glass cover. Table, of simple, sturdy construction, is cool and easy to operate, and may be used anywhere an electrical outlet is available. Comes in choice of masonite or Formica top, natural or walnut finish. W. R. Hausmann Woodwork, Inc., 1545 Inwood Ave., New York 52, N. Y.

224. Napkin shield

New napkin shield protective cover for sanitary napkins is made of pure white, soft absorbent foam backed by silky moisture-proof sanitized vinyl. Slits at each end of the shield for insertion of the tabs of the sanitary napkins make for simplicity, security and comfort with no bulkiness. Treated with germicide for additional protection and odor reduction. Compact dispenser, finished in pastel pink and blue, is 18¾" high, 5½" deep, 7½" wide, and holds 72 units. Napkin-Shield Co., 1029 Wabash Ave., Springfield, Ill.

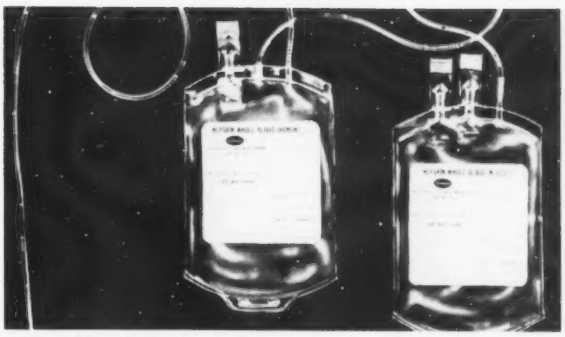


225. Electric pointer

An aid to group communication, new electric projection pointer, with a simple press of a button, casts a brilliant, sharply defined, non-spilling, contrasting arrow image over long projection distances. Excellent for speakers who must clearly indicate specific points of discussion on slides or charts, even in fully lighted arena or auditorium-sized locations. The sharp image, that shows up in brightly lighted rooms, is produced by precision ground Aspheric lens elements with all the properties of a fine optical instrument. Complete with cord, transformer, case. Ednalite Optical Co., Inc., 220 N. Water St., Peekskill, N. Y.

226. Table and chair combination

New table with attached chairs that permit a person to walk to his seat free of obstructions is folding and portable. Comfort provided by the individually supported chairs is augmented by their flexibility; capable of swiveling 180 degrees, they enable users to face away from table, in direction of activity. Unoccupied, chair automatically returns to position. Produced in 10′ lengths, the TC-65 will accommodate 12 persons. Folding in the middle, table and chairs can be rolled to storage areas and through doors. Sico Manufacturing Co., Inc., 5215 Eden Ave., Minneapolis, Minn.



227. Blood-Pack* unit

Heparin-ACD Blood-Pack, newly developed closed system of reducing heparinized blood for general blood bank use, incorporates two 500 ml. Blood-Packs joined by an intra-pack transfer tube. The primary collection pack contains 2,000 U.S.P. units of heparin in a 30 ml. solution of buffered isotonic sodium cloride. The auxiliary pack contains 75 ml. of ACD solution U.S.P. formula A. New unit was developed especially to save heparinized blood when it would ordinarily have been wasted as a result of last-minute changes in operative plans involving extracorporeal circulation. By expressing the heparinized blood through the transfer tube into the ACD Blood-Pack, the utilization period of the heparinized blood is extended to 12 days. Fenwall Laboratories, Framingham, Mass.

228. Pediatric cups

Jumbo Jungle, new design in waxed cold drink cups, ideal for pediatric wards, features a parade of animal caricatures, printed in red, white and blue, which differ with each cup size. The different illustrations provide quick identification of cup capacity. Ounce sizes include: 6 (kangaroos); 7 (tigers); 9 (hippopotamuses); 10 (camels); tall 12 (bears); wide base 12 (penguins); 14 (seals); tall 16 (lions); wide base 16 (elephants); 20 (zebras); and 24-ounce (giraffes). Continental Can Co., 100 E. 42nd St., New York 17, N. Y.

* Trademark

For further information see postcard opposite page 116.

stops surgical bleeding promptly!

OXYCEL

Absorbable Hemostatic

OXYCEL (oxidized cellulose, Parke-Davis) produces prompt hemostasis in capillary and other small-vessel bleeding not controllable by conventional surgical methods. Applied directly from container, OXYCEL readily conforms to all wound surfaces . . . shortens operative procedures and helps to prevent postoperative hemorrhage.

practical forms for every surgical need

OXYCEL PADS: Sterilized, gauze-type, 3″ x 3″ 8-ply pads, and 4″ x 12″ 8-ply pads.

OXYCEL PLEDGETS: Sterilized, cotton-type, 2¼″ x 1″ x 1″ portions.

OXYCEL STRIPS: Sterilized, 4-ply, gauze-type strips, 5″ x ½″; 18″ x 2″; 36″ x ½″; and 3 yd. x 2″, pleated in accordion fashion.

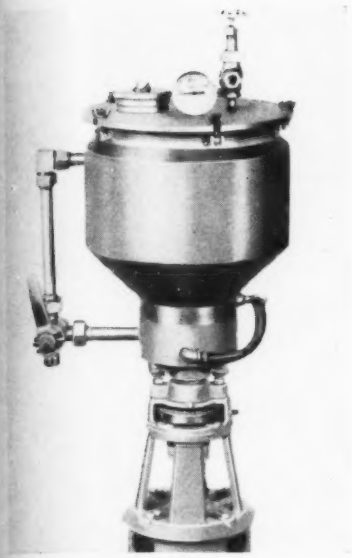
OXYCEL TOLEY CONES: Sterilized, 4-ply, gauze-type discs, 5″ and 7″ diameters, conveniently folded in radially fluted form.

Supplied in individual glass containers.

PARKE-DAVIS

PARKE, DAVIS & COMPANY · DETROIT 32, MICHIGAN

15560



229. Micro-mill

New mill, especially designed for rupturing large quantities of microorganisms, will reduce slurries and bacteria, spores, molds, yeast and pollen granules in hopper capacities ranging from 150 ml. to two liters. Unit is mounted on stainless steel dolly for portability and ease of installation. Powered by a 1.5 hp AC-DC motor with speed controls from 0 to 10,000 rpm monitored by continuously variable transformer. Unrefined material is fed into hopper, calibrated dial is adjusted to give desired particle breakdown, and material recirculated a specified length of time before discharge for analysis. Gifford-Wood Co., Hudson, N. Y.

230. Cream serving

Individual serving of cream in coffee creamer size is patented packaging method which affords savings by eliminating labor time for filling, washing, sterilizing. Unused creamers can be returned to storage without fear of spoilage. Inside lining of odorless, tasteless polyethylene cannot chip or flake or contaminate contents. Tetra-Pak Co., Inc., 939 Rahway Ave., Union, N. J.

231. Disposable washcloth

Soft, absorbent, non-woven fabric washcloths have feel and bulk of cloth. Use for patient bathing eliminates laundry, handling, cuts down possible cross-contamination. Porous construction gives proper cleansing action and super rapid drying which prevents "souring." In pink and green, size 13½" x 11". Johnson & Johnson, New Brunswick, N. J.

232. Patient gown

New longer plisse gown with Velcro shoulder closure eliminates snaps, ties, and buttons. The 45" de luxe gown has a larger overlap in back, reinforced neckline. Drip dry fabric does not shrink, is snow white in color, and attractive in design. A. S. Aloe Co. division, Brunswick Corp., St. Louis, Mo.

233. Disposable Petri dishes

New resealing cover for disposable, prepared Petri dishes eliminates need for sealers, keeps contents moist and ready for inoculation for extended periods of time. Rimseal plates can be opened by applying pressure across the cover. The selected medium dish is then streaked, and the plate resealed with gentle pressure on the cover. Any plate can be opened and closed repeatedly for examination of cultures and selection of colonies without cumbersome resealing procedures. Baltimore Biological Laboratory, Inc., division of Becton, Dickinson and Co., Baltimore, Md.

234. Infant bottle washer

New glass washer handles up to 1,200 bottles per hour, removing milk scum even from inner bottom crevices. Brushes available to fit wide-mouth, 8-oz. nursing bottles, as well as 8-oz. and 4-oz. nursing units. Unit, which is 9 5/16" wide by 18⅞" high, fits sink as small as 8½" x 10½", with a water depth as shallow as 5½". Four fast-revolving, motor-driven nylon brushes do the scrubbing. Gusher water action raises water to a 10½" level in outside cylinder, completely submerging brushes. Water from below, free from surface grease, washes and flushes bottles. Heavy-duty, rustproof construction, turn-top switch, removable brushes. Hamilton Beach, division of Scovill Manufacturing Co., Racine, Wis.

235. Rib nipple

New, exclusive Curity Rib Nipple has built-in hollow side channels to give it unique oval shape. These serve dual purpose in that they fit the corners of the baby's mouth, which helps reduce undesirable air intake, permit the continuous flow of liquids, even when the baby bites. Precision feeding holes are drilled at 12 mills to insure fast, continuous flow of liquids. In laboratory tests, nipple retained its uniform softness throughout repeated sterilizations. Helps eliminate feeding problems during crucial first six weeks. Another item in new Curity Nurser line is the "Sure Grip" bottle made of rugged shock resistant glass, its concave middle shaped to fit the hand. New cap and disc design makes it easier to push nipple through cap without touching it. Complete nurser unit available in four- and eight-ounce size. Bauer & Black Division, The Kendall Co., 309 W. Jackson Blvd., Chicago 6, Ill.

For further information see postcard opposite page 116.

Films, New Literature

240. Respiratory epithelium
New technical film, *The Effect of Acetylcholine, Eserine and Atropine on Human Ciliated Respiratory Epithelium*, was photographed through microscopes in the tissue culture laboratory at the University of Texas Medical Branch at Galveston. Film shows how epithelium fragments obtained by means of small caliber biopsy punch from the human trachea and bronchus curl up and form globes which rotate as a result of actively beating cilia. These cell clusters are exposed to various cholinergic substances and related compounds which bring about such changes of the ciliary beat as acceleration, deceleration, and stoppage. Abbott Laboratories, North Chicago, Ill.

241. Resuscitation film
Resuscitation of the Newborn, 25-min. 16 mm. color-sound film, illustrates essential principles involved in resuscitation of infants who do not breathe – or whose respiration is impaired – at birth. Procedures shown are those developed by the special committee on infant mortality of the Medical Society of the County of New York. Smith Kline & French Laboratories, Philadelphia, Pa.

242. Radiation meters
New four-page bulletin features latest portable models for medical laboratory use. Shown are two geiger counters sensitive to beta and gamma radiation, one geiger counter sensitive to soft x-ray, alpha and beta radiation, and a scintillation counter. Nuclear Measurements Corp., 2460 N. Arlington Ave., Indianapolis 18, Ind.

243. Hospital restraints
New catalog on restraints includes a complete line of belts and straps, wristlets and anklets with slots and metal staples in both vertical and horizontal positions to provide maximum comfort; complete line of mitts and muffs for extreme cases – light-duty items for mild restraint. Also included are operating table wristlets and anklets. Illus. Humane Restraint Co., Box 16, 824 E. Johnson St., Madison 1, Wis.

244. Drapery fabrics
New collection of fiberglass drapery fabrics for hospitals includes cubicle curtain fabrics as well as fabrics for window areas. A total of 128 samples are given, all of them stain-resistant, odorless, and inherently fireproof. Long-wearing, never need ironing. Glass Fabrics, Inc., Hospital Division, 620 N. Almont Drive, Los Angeles 46, Calif.

SEPTISOL = Confidence
HEXACHLOROPHENE SURGICAL DETERGENT

Since 1948 more than 300,000,000 pairs of hands in over 3,000 hospitals have proven SEPTISOL'S leadership.

Vestal's 3-Dimensional Procedure for the Preparation of patients and surgical 'teams'

- Rapid Skin degerming . . . with TINCTURE SEPTISOL
- "Continuous" anti-bacterial action . . . with AQUEOUS SEPTISOL
- "In-between-washes" bacterial control—with SEPTISOL ANTISEPTIC SKIN CREAM
- Mild, gentle, satisfying skin asepsis

VESTAL

VESTAL, INC.
PHARMACEUTICAL DIVISION
4963 Manchester Ave.,
St. Louis 10, Mo.

JERSEY CITY, NEW JERSEY
MODESTO, CALIFORNIA

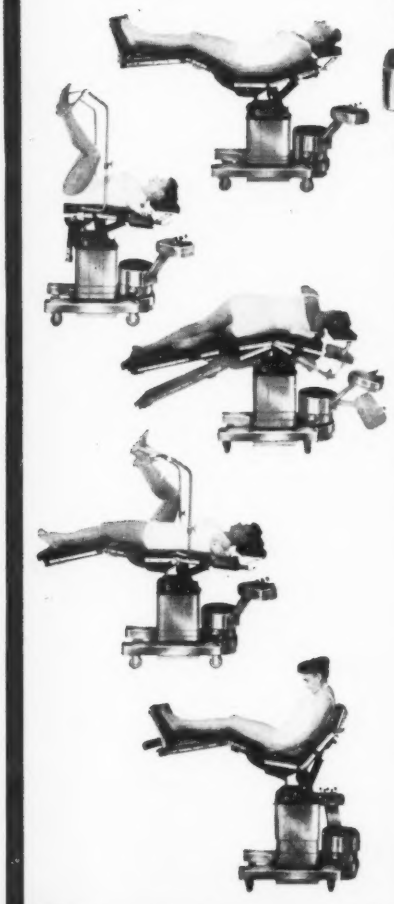
Announcing

A FIRST IN SURGICAL HISTORY

Operating Table

with 5 Sections!

...FOR UNLIMITED POSITIONING IN ALL SURGICAL PROCEDURES



Here's the world's first major operating table with *five* articulating sections . . . to provide contour-correspondence with the patient's *five* anatomical regions: head, spinal, pelvic, femoral and lower-leg.

Now telescoping spinal and femoral sections assure precise positioning for patients, short or tall. Thus the Castle Table offers unlimited provision for the most favorable surgical exposure consistent with physiologic function.

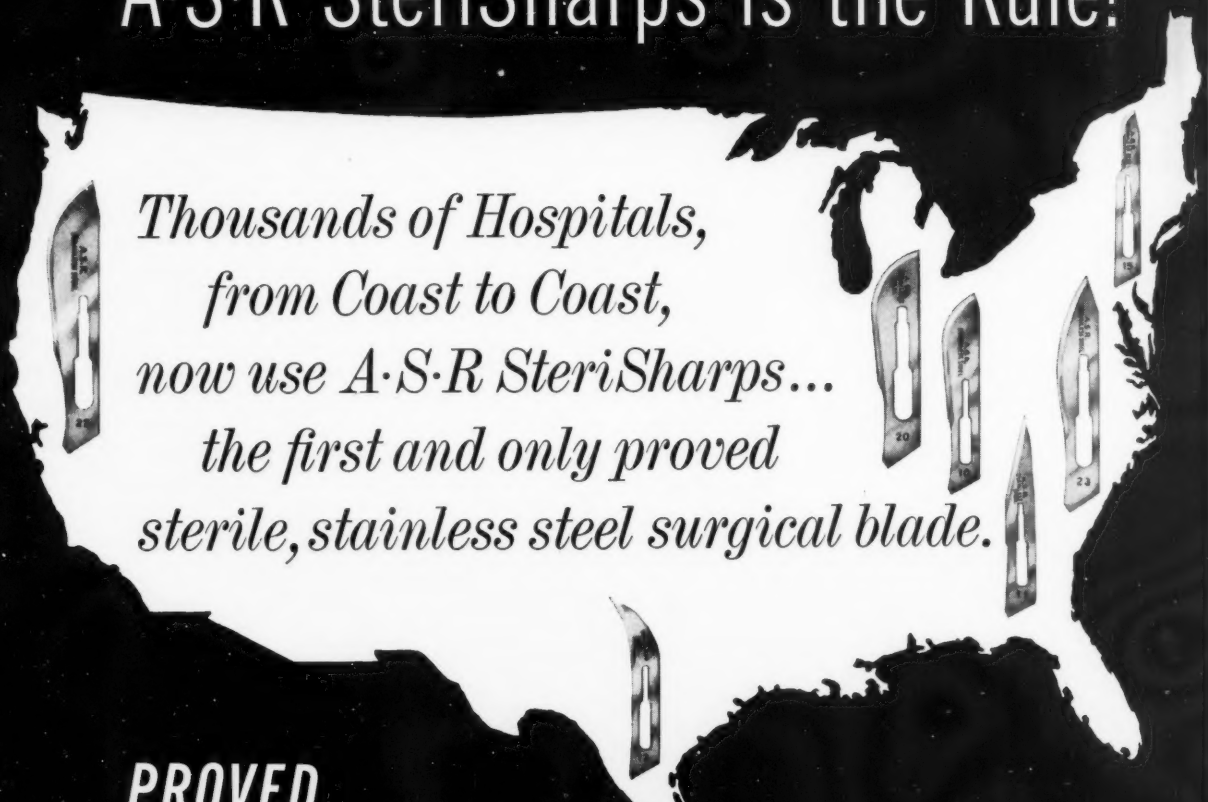
A movable control cluster lets the anesthesiologist control height, longitudinal and lateral tilt, and all the unlimited adjustments, with *one* hand, from a selection of convenient positions. Safety features throughout help to make this "the contribution of the century in operating table design."

WRITE for information on this new concept in tables for major surgery.

Castle

WILMOT CASTLE CO., 1703-9 E. HENRIETTA RD., ROCHESTER 18, N.Y.

where PERFECTION is the Standard–
A·S·R SteriSharps® is the Rule!



Thousands of Hospitals,
from Coast to Coast,
now use A·S·R SteriSharps...
the first and only proved
sterile, stainless steel surgical blade.

PROVED

Uniform Sharpness—Assured by constant inspections utilizing the A·S·R Sharpometer® —an electronic device of mathematical precision.

Longer Lasting—A unique stainless steel alloy insures a sharper edge that stays sharp longer. The cutting edge is unaffected by the corrosive action of body fluids, sterilizing solutions and autoclaving.

Sterility and Convenience—Heat sterilized in their individual foil packages, they are pathogen free. Blade edges are protected from the dulling effects of handling.

A·S·R SteriSharps

A·S·R PRODUCTS COMPANY, HOSPITAL DIVISION, 380 MADISON AVENUE, NEW YORK 17, NEW YORK

In Canada: A·S·R HOSPITAL DIVISION, 2055 DESJARDINS AVENUE, MONTREAL, CANADA

TRADE TOPICS . . .

In recognition of high academic standing, industry, and leadership, Lawrence B. Dillehay (r), administrator, City Hospital, Bellaire, O., is winner of the thirteenth Mary H. McGaw award. The $200 honorarium and certificate is provided by Foster G. McGaw, founder and chairman of American Hospital Supply Corp., to a graduate of Northwestern University's hospital administration program. James P. Ince, director, public relations and advertising, is shown presenting the award.

Baird-Atomic Makes New Appointments

Bernard C. Lindstrom, Richard P. MacCarthy and James J. Matthews, Jr., have joined the spectrochemical division staff, Baird-Atomic, Inc., and will represent the firm in the Pittsburgh, Chicago and Northeast districts, respectively.

Mervyn J. Dunscombe has been named manager of Canadian sales, and Charles B. Meade, district manager, New England sales, for the firm's Atomic Instrument division.

American Hospital Joins Stanford Research Institute

American Hospital Supply Corporation has joined the non-profit Stanford Research Institute, Menlo Park, Calif., as an associate member. The company has also received an award for distinguished achievement in its annual financial reporting from *Financial World*, the weekly financial news magazine. The company's 1959 annual report to share owners was selected on the basis of content, design and typography from among 5,000 entries in the publication's 20th Annual Report Survey.

Announcements From Mead Johnson

Mead Johnson & Co. has acquired the Brazilian firm of Industria Farmaceutica Endochimica, S. A., which will continue to operate as a separate corporation, headed by S. W. Kapranos, Mead Johnson's vice-president, Latin American operations.

J. Emmett Terrell has been promoted to the new post of sales manager in charge of field sales operations, Mead Johnson's nutritional and pharmaceutical division.

American Cyanamid Adds To Its Sales Force

John J. Spillane, Jr., has been assigned to a New York City and adjacent metro areas sales territory, American Cyanamid's surgical products division. Also named to the division are George Parker, who will serve the state of Oklahoma, and Jacob W. Hoover, who will serve the northwest area. Mr. Hoover was formerly with Cyanamid's Lederle laboratories division.

* * *

Max Enelow – has retired as director of advertising and sales promotion, Philco Corp.

* * *

American Hospital Supply – has opened a new area sales and distribution center, Miami, Fla., with **Edwin M. Robinson** managing regional services and **M. Richard Gallman,** scientific products.

* * *

Hygrodynamics, Inc. – has been organized as a new subsidiary of American Instrument Co., Inc. Offices, engineering and manufacturing facilities are in Silver Spring, Maryland.

* * *

Fisher Scientific Co. – has acquired Industrial Scientific, Inc. ISI's three branches and one sales office have become Fisher's new southwestern division.

* * *

Donald L. Hamm – president, M. M. Teare Co., Inc., has assumed active management upon the retirement of **Margaret Teare** who will continue in an advisory capacity with the company.

* * *

Daniel B. Lamb – has been appointed manager, Detroit division, Oakite Products, Inc., replacing **T. R. Smith** who is retiring.

* * *

William C. Drohan – has been appointed supervisor, product engineering, laboratory glassware sales department, Corning Glass Works.

(*Continued on page* 115)

Prize-winning design team from Walter Dorwin Teague Associates receives an Industrial Designers Institute award and citation for their creation – the Ritter Company's eurphorian chair (in foreground). Shown from l. to r. are F. Ritter Shumway, president, Ritter Company, Inc., and Walter Dorwin Teague, Jr., Benjamin H. Stanbury, David H. Deland, all of Walter Dorwin Teague Associates.

The euphorian dental chair is "human-engineered" to "cradle" the patient in a semi-reclined position during dental procedures.

For further information see postcard opposite page 116.

A NATURAL FOR THE NEW MOTHER– WITH BUILT-IN GOOD WILL FOR YOU!

DAVOL® FORMULA SERVICE PLAN

FEED-RITE PLASTIC #274-P

	Hospital Price	Selling Price to Mothers
2 gross lots	$1.44 per carton	$2.65 per carton
5 gross lots	$1.38 per carton	$2.65 per carton

DURAGLAS #154-P

	Hospital Price	Selling Price to Mothers
2 gross lots	$1.15 per carton	$2.00 per carton
5 gross lots	$1.05 per carton	$2.00 per carton

DAVOL FORMULA SERVICE PLAN helps mother and baby make a smooth transition from the hospital to the home. Here's how it works–

1. Hospital buys Davol "Handy-Packs." Each pack holds 6 Davol DURAGLAS or FEED-RITE Nursers – enough for a 24-hour supply of take-home formula.
2. Hospital offers mothers a 24-hour supply of formula in Davol Nursers for the regular retail price of empty Davol Nursers.
3. Hospital buys at special price–provides an improved patient service at a profit.
4. "Handy-Packs" eliminate need for hospital to supply its own containers . . . simplify mother's first day at home.
5. Davol supplies handy order forms for distribution to maternity patients. A special order form for each plan.

Davol Duraglas and Feed-Rite Nursers are guaranteed by Good Housekeeping Magazine. Come complete with famous Davol Nipples–specially vented to regulate flow of formula, prevent clogging and nipple collapse. Davol nursers and parts are readily available at neighborhood drug or department stores.

ALSO AVAILABLE

#254-P Feed-Rite Plastic with nipple inverted

#174-P Duraglas with nipple upright and with cover

CONTACT YOUR HOSPITAL SUPPLY DEALER OR WRITE–

DAVOL® RUBBER COMPANY
PROVIDENCE 2, RHODE ISLAND

For further information see postcard opposite page 116.

(Continued from page 113)

Charles French – has been appointed manager of the newly formed scientific instruments division, Polorad Electronics Corp.

* * *

Julian Conway – has been elected president of the newly established Ultrasonic Industries (Canada) Ltd., a subsidiary of Ultrasonic Industries, Inc.

* * *

Picker X-Ray Corp. – has been named U. S. agent for Associated Electrical Industries Ltd. (Great Britain).

* * *

Charles D. White Co. – has been appointed New England representative (with the exception of Connecticut) for Dynaray Emergency Lighting Equipment.

* * *

B. Lewis Burton – has been named head, medical division, Enyart & Rose Advertising. Mr. Burton is a former medical and hospital public relations consultant.

* * *

Harvey E. Giss – has been appointed manager, advertising and professional relations, Armour Pharmaceutical Co. He was formerly manager, market research.

* * *

Kenneth M. Hopkins – has been appointed design consultant in charge of the account for F & F Koenigkramer Co. by Lawrence H. Wilson & Associates.

* * *

W. Brooks Martin – has been appointed sales representative, food service management division, Mannings, Inc.

* * *

Isadore Farber – has been named pharmacologist, scientific laboratories section, pharmaceutical laboratories division, Schieffelin & Co.

* * *

Abraham S. Jacobson, M.D. and **William F. B. O'Donnell** – have been elected vice-presidents, William Douglas McAdams, Inc.

* * *

John Kapp Clark – has been named director of research and development, Smith Kline & French Laboratories, Philadelphia. Dr. Clark, who had been SK&F's Director of Research, succeeds **W. Furness Thompson,** who has resigned as vice-president of research and development.

* * *

Fred Geck Awards for outstanding papers in the field of hospital administration, sponsored by **American Cyanamid Company,** were presented this year to **David W. Stickney,** administrative assistant, Children's Memorial Hospital, Chicago, and **Francis J. Blaise,** an administrative resident, St. Luke's Hospital, Racine, Wisc. The awards are made each year to two graduate students who have submitted outstanding papers in qualifying for their master's degrees in hospital adminstration.

* * *

Lewis J. Bell – has been appointed regional manager, Clay Adams, Inc., and will be responsible for all sales activity in Illinois, Michigan, Wisconsin, Indiana, Ohio and western Pennsylvania.

* * *

Everett F. Knust has joined the Schuco international division of Schueler & Co. as assistant to the president. He was formerly vice - president and general manager, Genelectric Royos X, S.A. of Cuba.

* * *

Ellsworth Alan Roberts – president and director of the Fidelity Mutual Life Insurance Co., died June 29. He had served as a director of the Philadelphia Community Chest, and a director of the executive committee, Pennsylvania Health and Welfare Fund. A firm supporter of medical research, Mr. Roberts also served as a trustee and senior vice-president, Hahnemann Medical College and Hos-

(Continued on next page)

ANCHOR
ALL-NYLON
SURGEON'S BRUSH

112 lifetime tufts anchored in non-corrosive nickel silver

Guaranteed 400 times—each Anchor All-Nylon Surgeon's Brush is guaranteed to withstand a minimum of 400 autoclavings

Tufts are soft but firm and especially tapered for better scrub-up efficacy with more comfort

Grooved handles assure firmer grip ...crimped bristles retain soap better

Satisfied users are one of your hospital's best assets. Why not please your surgeons by getting the best. Outstanding performance makes Anchor brushes the most economical on the market.

ORDER BY THE DOZEN OR BY THE GROSS THROUGH YOUR HOSPITAL SUPPLY FIRM

Other outstanding Anchor products...
Stainless Steel Surgeon's Brush Dispenser
All-Nylon Emesis Basin
All-Nylon Drinking Tumblers

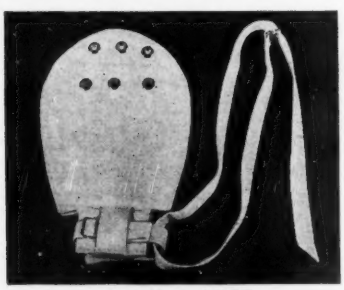
Sold Only Through Selected Hospital Supply Firms
ANCHOR BRUSH COMPANY
AURORA, ILLINOIS
Write for Complete Information to Exclusive Sales Agent:
THE BARNS-ELY COMPANY
1414-A Merchandise Mart • Chicago 54, Illinois

For further information see postcard opposite page 116.

For Patient Protection

The Posey Safety Belt
Prevents patients falling out of bed. Cat. #S-141, $6.45. (Extra heavy construction with key-lock buckles. Cat. #P-453, $19.50 each.)

The Posey "V" Restraint
A good all-purpose restraint to prevent patients from falling or getting out of bed. Particularly good for use on females as it does not irritate busts. Available in Small, Medium, and Large sizes. Posey "V" Restraint Cat. No. V-958. Price $6.90 each.



The Posey MITT
To limit the patient's hand activity. An adjustable strap attached to the mitt and the side rail of the spring determine limit of movement. Can be laundered by ordinary methods. Comfortable and prevents patient's scratching, pulling out catheter, nasal tube, etc. Available small, medium and large.

Cat. No. C-212—(both sides flexible) $6.00 ea.—$12.00 pr.
Cat. No. R-212—(palm side rigid) $6.30 ea. $12.60 pr.

SEND YOUR ORDER TODAY
And Write for Illustrated Literature About Other Posey Hospital Equipment

J.T. POSEY COMPANY
2727 E. Foothill Blvd.
Dept. HT
Pasadena, California

pital, and was a member of the board of the Hospital Council of Philadelphia.

* * *

Carl F. Everleigh – executive vice-president of Eli Lilly & Co., died on June 13. Mr. Everleigh joined the firm in 1912 and had been closely associated with the company's financial structure.

* * *

Edward J. Ledder Jr. – has been appointed assistant director of sales in charge of product promotion at Abbott Laboratories.

* * *

American Sterilizer Company – has announced the formation of a new electronics division, to be known as Amsco Electronics. Gilbert G. Brown will serve as general manager and Cecil Ruegge as chief engineer. The new division will be located in Palo Alto, California.

* * *

John A. McCartney – formerly director of professional relations, Parke, Davis & Company, has been appointed director of public relations. He will replace **Ralph G. Sickels**, who is planning to retire.

* * *

Paul Brown West—president of the Association of National Advertisers, died May 5. He was one of the founders and incorporators of the bureau and its first elected president.

* * *

D. J. Wallensack – has been appointed personnel manager, A. S. Aloe division of Brunswick Corporation. He will handle all personnel and labor relations relating to the division and will have offices in the Aloe home office, St. Louis.

* * *

A citation of appreciation has been presented to **Schieffelin & Co.**, New York City, by the New Jersey Association for Mental Health in recognition of a gift of $75,000 in cosmetics to launch a patient good grooming program in state and county mental hospitals.

* * *

All autoclave sterilization tubing lines of Northwestern Converting Company have been acquired by **Aseptic-Thermo Indicator Company**, North Hollywood.

Edward S. Edwards has been appointed manager of the New York office, Hospital Equipment Division, Overseas Service Corporation.

* * *

Joseph P. Patrick has been appointed to the field staff of Clay Adams, Inc. He will represent the company in the Dakotas, Nebraska, Iowa and Minnesota, with headquarters in Minneapolis.

* * *

James Ruff—has been appointed manager of marketing services, American Hospital Supply Corporation. He will be responsible for correlating market research, economic forecasting and product planning for the corporation's 25 component divisions and subsidiaries.

* * *

Paul Magers is new general manager of DePuy Manufacturing Company, Inc., Warsaw, Indiana. He was formerly general manager, Zimmer Manufacturing Company, Warsaw, Ind.

* * *

J. R. Brown, Jr., – formerly manager, medical products department, Cyanamid of Canada, Ltd., has been appointed assistant general manager of American Cyanamid Company's surgical products division.

* * *

Chicago Apparatus Company will present its 2nd Annual Scientific Instrument Exhibit September 22-23 at the Edgewater Beach Hotel, Chicago. Thirty-six exhibitors are expected, including automatic analyzers, chemicals, pH equipment, furnaces, heaters, microscopes, ovens, spectrophotometers, etc.

BUYER'S GUIDE Information Service

BUYER'S GUIDE

200. pH meter
201. Cardiac monitors
202. Tube
203. Sprayer
204. Refrigerated centrifuge
205. Disposable syringe
206. Hot/cold door
207. Sterilization paper
208. Incubator
209. Brush
210. Pump oxygenator
211. Instrument lavatory
212. Caution stand
213. Portable aspirator
214. Diagnostic aid
215. Hydro-hotpak
216. Audiometric room
217. Blood pressure cuff
218. Phone message book
219. Cardiometer, monitor oscilloscope
220. Thermo-Fax recording paper
221. Portable oxygen unit
222. Measuring tape
223. Linen inspection table
224. Napkin shield
225. Electric pointer
226. Table and chair combination
227. Blood-Pack unit
228. Pediatric cups
229. Micro-mill
230. Cream serving
231. Disposable washcloth
232. Patient gown
233. Disposable Petri dishes
234. Infant bottle washer
235. Rib nipple

FILMS, NEW LITERATURE

240. Respiratory epithelium
241. Resuscitation film
242. Radiation meters
243. Hospital restraints
244. Drapery fabrics

USE THIS CARD

Just circle the number on the postpaid reply card for information you would like.

Inquiries will be accepted for three months following date of issue.

Postage Will Be Paid by Addressee

No Postage Stamp Necessary If Mailed in the United States

BUSINESS REPLY CARD
First Class Permit No. 53134, Chicago, Illinois

HOSPITAL Topics
30 West Washington Street
Chicago 2, Ill.

Z-1	Z-13	Z-25	Z-37	Z-49	205	217	229
Z-2	Z-14	Z-26	Z-38	Z-50	206	218	230
Z-3	Z-15	Z-27	Z-39	Z-51	207	219	231
Z-4	Z-16	Z-28	Z-40	Z-52	208	220	232
Z-5	Z-17	Z-29	Z-41	Z-53	209	221	233
Z-6	Z-18	Z-30	Z-42	Z-54	210	222	234
Z-7	Z-19	Z-31	Z-43	Z-55	211	223	235
Z-8	Z-20	Z-32	Z-44	200	212	224	240
Z-9	Z-21	Z-33	Z-45	201	213	225	241
Z-10	Z-22	Z-34	Z-46	202	214	226	242
Z-11	Z-23	Z-35	Z-47	203	215	227	243
Z-12	Z-24	Z-36	Z-48	204	216	228	244

Send more information on items circled, SEPTEMBER, 1960
This card expires November 30, 1960

Name_____ Position_____
(Please Print)

Hospital_____

Address_____

City_____ Zone_____ State_____

BUYER'S GUIDE Information Service

ADVERTISERS' INDEX

		Page			Page
Z-1	American Cyanamid Co.	89, 90	Z-11	Becton, Dickinson & Co.	Cover 3
Z-2	American Hospital Supply Corp.	2, 3	Z-12	Bunn Corp., John	96
Z-3	American Sterilizer Co.	8	Z-13	Carolina Absorbent Cotton Co.	99, 100
Z-4	American Sterilizer Co.	65	Z-14	Castle Co., Wilmot	111
Z-5	Anchor Brush Co.	115	Z-15	Chick, Gilbert Hyde Co.	52
Z-6	Armstrong Co., Inc., The Gordon	14	Z-16	Classifieds	101
Z-7	A.S.R. Products Corp.	112	Z-17	Clay-Adams, Inc.	4
Z-8	C. R. Bard, Inc.	104	Z-18	Clyserol Laboratories, Inc.	98
Z-9	Baxter, Inc., Don	17, 18	Z-19	Crescent Surgical Sales Co.	64
Z-10	Baxter Laboratories, Inc.	Cover 4	Z-20	Cutter Laboratories	53, 54

Z-1	Z-13	Z-25	Z-37	Z-49	205	217	229
Z-2	Z-14	Z-26	Z-38	Z-50	206	218	230
Z-3	Z-15	Z-27	Z-39	Z-51	207	219	231
Z-4	Z-16	Z-28	Z-40	Z-52	208	220	232
Z-5	Z-17	Z-29	Z-41	Z-53	209	221	233
Z-6	Z-18	Z-30	Z-42	Z-54	210	222	234
Z-7	Z-19	Z-31	Z-43	Z-55	211	223	235
Z-8	Z-20	Z-32	Z-44	200	212	224	240
Z-9	Z-21	Z-33	Z-45	201	213	225	241
Z-10	Z-22	Z-34	Z-46	202	214	226	242
Z-11	Z-23	Z-35	Z-47	203	215	227	243
Z-12	Z-24	Z-36	Z-48	204	216	228	244

Send more information on items circled, SEPTEMBER, 1960
This card expires November 30, 1960

Name_____ Position_____
(Please Print)

Hospital_____

Address_____

City_____ Zone_____ State_____

Postage Will Be Paid by Addressee

No Postage Stamp Necessary If Mailed in the United States

BUSINESS REPLY CARD
First Class Permit No. 53134, Chicago, Illinois

HOSPITAL Topics

30 West Washington Street
Chicago 2, Ill.

The Advertisers' Index will appear on this card every month. Further information on products listed in advertisements may be obtained by circling the appropriate number on the reply card.

Inquiries will be accepted for three months following date of issue.

		Page
Z-21	Davol Rubber Co.	114
Z-22	Deknatel, J. A., and Son, Inc.	61
Z-23	Dennison Mfg. Co.	97
Z-24	Duxe Products	98
Z-25	Ethicon, Inc.	74
Z-26	Halliday, Thomas W.	82
Z-27	Hill-Rom Co.	66
Z-28	Hollister, Inc.	35, 36
Z-29	Hollywood Turban Products Co.	82
Z-30	Hypo Surgical Supply Co.	46
Z-31	Johnson & Johnson	71, 72
Z-32	Kadan Co., Inc., D.A.	101
Z-33	Kendall Co.	15
Z-34	Kendall Co.	60
Z-35	Lin Co., The	70
Z-36	Lorvic Corp.	48
Z-37	Meinecke & Co., Inc.	88
Z-38	Minnesota Mining & Mfg. Co.	10
Z-39	V. Mueller & Co.	62
Z-40	Parke, Davis & Co.	100
Z-41	Perry Rubber Co.	86
Z-42	Physicians' Record Co.	12
Z-43	Pioneer Rubber Co.	47
X-44	Posey, J. T. Co.	116
Z-45	Professional Tape Co.	6
Z-46	Will Ross, Inc.	13
Z-47	Rotary Hospital Equipment Corp.	50
Z-48	Shampaine Electric Co.	1
Z-49	Sierra Engineering Co.	16
Z-50	J. Sklar Mfg. Co.	73
Z-51	Smith & Underwood	83
Z-52	Tamblyn & Brown, Inc.	94
Z-53	Vestal, Inc.	110
Z-54	Weck & Co., Edward	57
Z-55	Winthrop Laboratories	Cover 2

FOR TECHNIC PERFECTION IN BLOOD COLLECTION...

NEW B-D VACUTAINER® sterile disposable needle

reduces risk of cross-infection— a new, factory-sharp needle for every venipuncture

a B-D DISCARDIT product

SAFE
re-use is precluded... plastic hub cannot withstand conventional re-sterilization

UNIQUE
the first truly disposable needle available for use with evacuated tubes

ECONOMICAL
preparation of needle and post-use handling eliminated

CONVENIENT
ready for immediate use... individually packaged in handy, sterile units

and B-D VACUTAINER® evacuated specimen tube

offers the **simplest** and most **efficient** means of obtaining quality blood specimens

PROVEN BY OVER 10 YEARS' EXPERIENCE

SUPERIOR STOPPER
easy to clean...
easy to use...
easy to remove

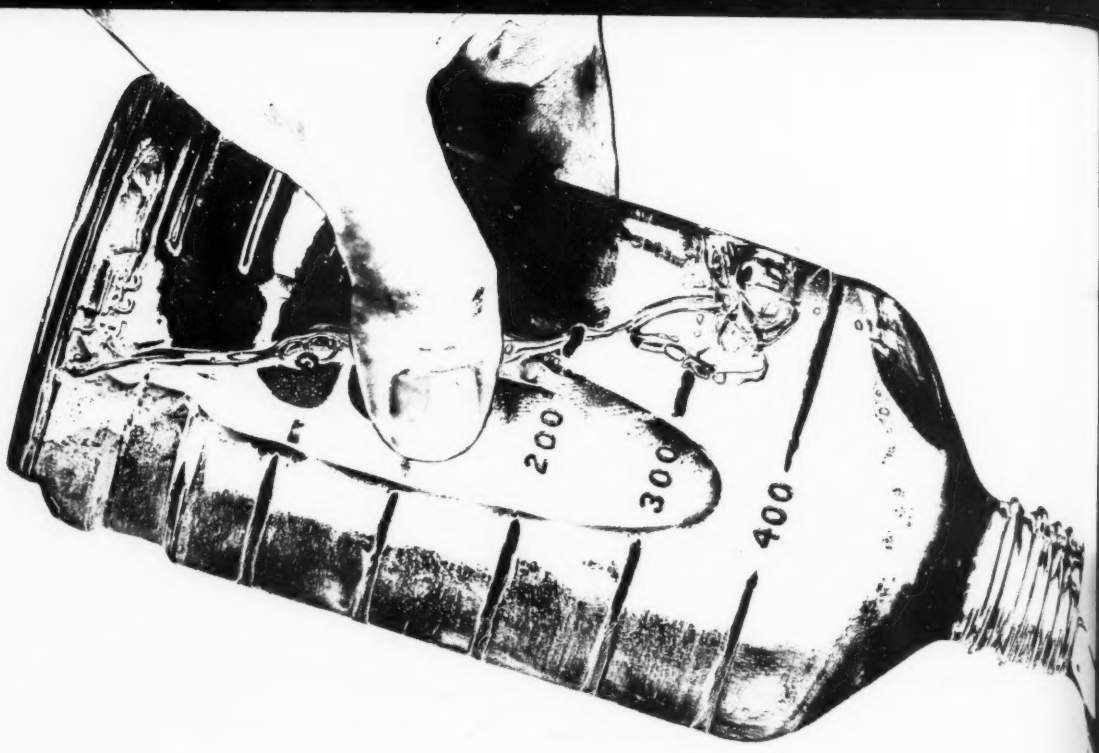
STRAIGHT SIDE TUBE
easy pouring...easy pipetting of serum, plasma or whole blood... easy removal of clots

WIDE RANGE OF USES
six different sizes and 45 different anticoagulants and preservatives ...color-coded according to usage

BECTON, DICKINSON AND COMPANY
RUTHERFORD, NEW JERSEY

B-D, VACUTAINER, AND DISCARDIT ARE TRADEMARKS

72559



more to Pour than ever before

the Pour Bottle system

In operating room, pharmacy, central supply, laboratory...in fact, all over the hospital, more solutions are being poured than ever before in irrigation, washing and rinsing procedures. Pour bottles fill immediate needs for sterile uniform solutions—and they keep right on working since they can be re-used as dispensing or storage bottles for hospital-prepared items and as drainage bottles. Let our representative explain the complete **pour bottle system** for economical **use**—profitable **re-use** ...or write for illustrated brochure.

BAXTER LABORATORIES, INC.

MORTON GROVE, ILLINOIS

Distributed and available in the 37 states east of the Rockies (except in the city of El Paso, Texas) through

AMERICAN HOSPITAL SUPPLY CORPORATION

Parenteral Products Division, Evanston, Ill.